Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death <sup>Day</sup> 2000 Month Syvalia Moseby, Sr. March 22, 9:25AM 4a Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
NOV. 13, 1911 Rocky Mount, NC 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1♥M 2□F 88 239-12-5649 Yrs Usual Residence of Decedant 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1812 Ironton Drive 20745 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva Black. 1 Yes 2 No Specify: Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 6th College (1-4or 5+) Textile Worker Cotton Mill (private) 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumame) Lula (maiden unknown) Moseby Littlebuen Moseby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) 20745 Oxon Hill, Maryland Christine Suggs/ Daughter 1812 Ironton Drive 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 3-28-00 ROCKY MOUNT, NC NORTHEASTERN CEMETERY 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licenses 22. Name and Address of Facility Marshall's Funeral Home of MD 20746 Suitland, MD 4308 Suitland Rd. 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Congestive Cardiac Failure Immediate Cause (Finel disease or condition resulting In death) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as e consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Donknown 1 Yes 2 No 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 10 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Wes case rafarrad to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menne of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending 1 TYes 2 □ No invastigetion 2 Accident

and physician s the burial Box 68760 attending Division of Vital Records, P.O. å signed by 8 page 2 certificate 青 After Attending

Physician/Medical à Completed 88 2 Certification:

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

8

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Hedical Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours after (Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or her any Injury or other traumatic event, the Medical Empirical Empirical Colors.

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0020

death with the Maryland

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al Medical

6 ☐ Could not be datermined

3 Suicida

29a. Cartifie

4 Homicida

(Check only one)

29c. License number 18895

Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Data signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

7610 CARROLL AVENE, TAKOMA PARK, MD 20912 MOBARAK 31. Date filed (Month, Day, Year)
MAR 2 4 2000

State Registrar

32 Registrar's Signature

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

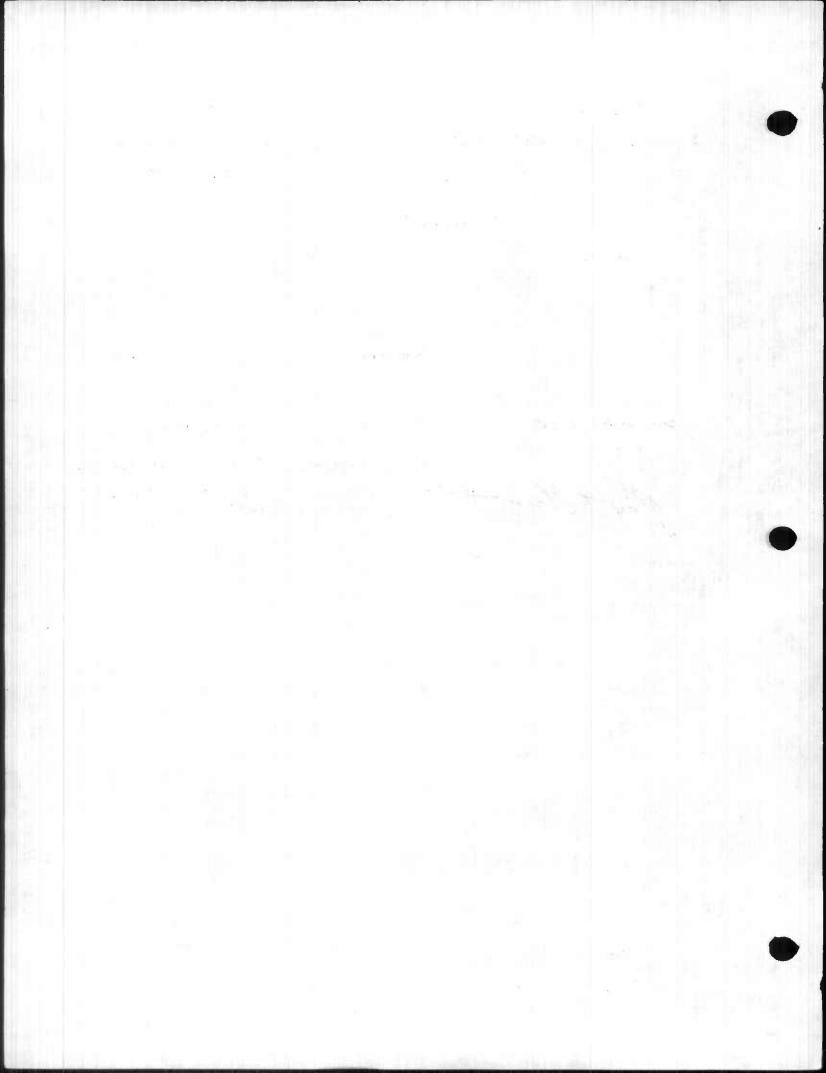
Barrens James Jr.

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 1 5 0 2

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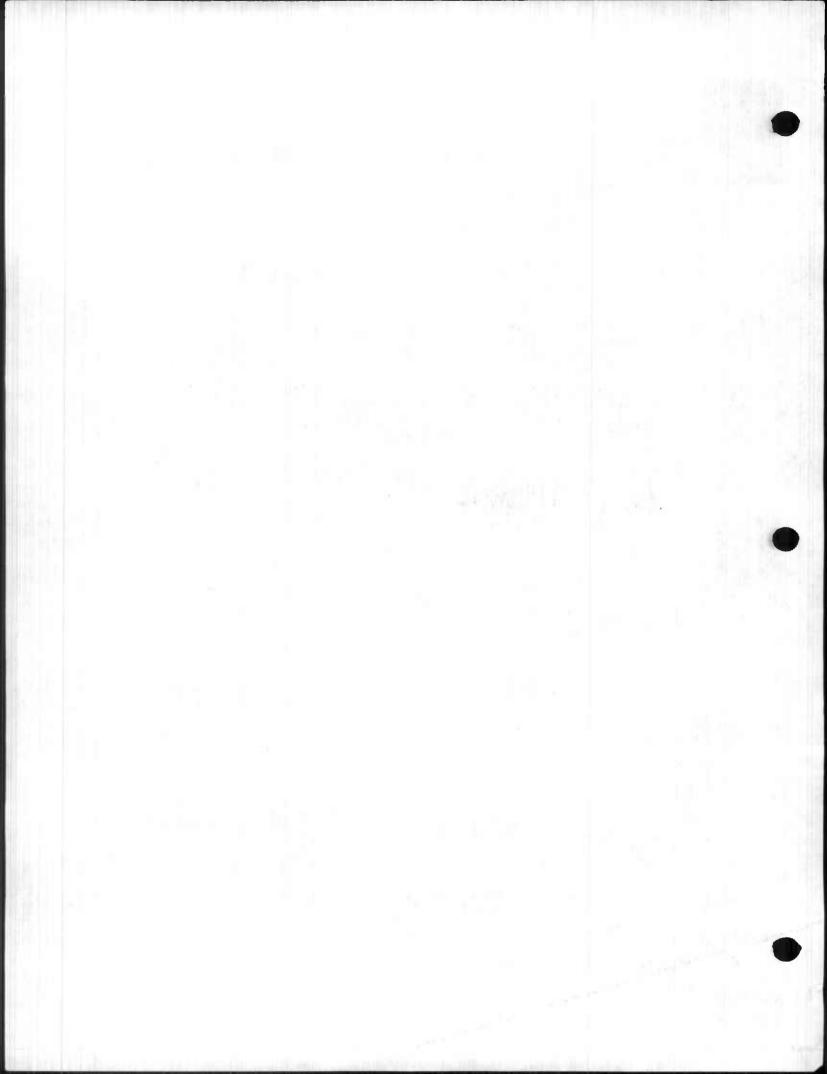


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death

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altimore mit. Pages 1 - partment of He portant: if Iher y Injury or oth	1 Burial 2 Cremetion 4 Donation 5 Other (S		10		ervice Co		3-27-00	Towson	n, Mai	ryland			
Bail Seemit Seemit Moort	21. Signature of Funeral Service Licenses  22. Name and Address of Facility McComas Funeral Home, P.A.  1317 Cokesbury Rd., Abingdon, Maryland 21009												
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Registrar MAR 2.7.2

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 | 1504

					Cer	tificate	of Dea	ath	Я	eg. No.		
	Decedent's Nama (First, Middle, Last)								2. Data of Dea			3. Tima of Death
sician	LILLIE	E MAE ROSI	EBOROUG	Н					Month MARCH	Day 16,2000	Yaar	9:35am
edical miner		If not institution, give					4b. Cit	ty, Town, or Lo	cation of Death	4c. County	of Death	) • 35 am
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al .	5. Social Sacurity N			7. Aga (In yrs. la	st birthday)	If Undar 1 Y		Indar 24 Hrs.	9 Date of Birth			
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ect	MD	PRINCE (	3EURGES	OXC	ON HIL							
Directo	10e. Street end Nu	mber				10f. Zip Co	oda		,	0g. Citizen of V	Vhat Cour	ntry?
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State of Maryland / Department of Health and Mental Hygiene

11505. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 20, DOUGLAS March 2000 HOLMES SMITH 9:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Fallston

| Hours | Min. | 8. Date of Birth (Month, Day, 2/13/1 Fallston General Hospital Harford If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Months Days 218-18-2904 78 Maryland Director **Usual Residence of Decedent** permit. Peges 1 and 2 should be filed within 72 hours effer death with the Merylan Department of Heelth and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or frams 23s or 28s-f show any Injury or other traumatic avant, the Medical Examiner must be notified at 0000s. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD. Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4337 Madonna Road 21154 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Bleck, White, etc. 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: Specify: Caucasian by 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Farming Dairy Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Smith Roberta Gardiner Eager Howard 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Rose T. Smith /Wife same as #10 a,b,c,e,f 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Madonna, Maryland 22. Name and Address of Facility
E.G. Kurtz & Son Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused in the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Jarrettsville, Maryland Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Se0515 couple of days Dyndrome Examiner Due to (or as a consequence of): Examiner physicien and s the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed ungestive Hear 1 ☐ Yes 2 ☐ No 1□ Yes 2 No of Vital 25. Wes case referred to examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After this 28a. Dete of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Attending - Natural Division To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 | Yes 2 | No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of curtile 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Maryland MAPHEL XZXI M 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State MAR 2 2 2000 Registrar

**DHMH 16 Rev 6/95** 

Sovalas Smith

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Item 23a bore DR., G782, 4/1/00dhb Certificate of Death Amend# 23a.Per Phys. PGC 3-23-2000 cr 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marjorie H. Silver March 16,2000 11:50 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2♥F 81 010-10-7063 Yes Director September 10,1918 Massachusett Usual Residence of Decedant 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Brandywine 1 Yes XIX No Maryland Prince Georges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20613 U.S.A. Funeral 13207 Baden Westwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give ^^ Yeer or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) University of Maryland Director of News Services nd 2 should be filed very and Mentel Hygie 27 is marked other if traumatic event, it 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Melyson Frank Newton Huxley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth a 1091 Lower Pindell Rd. Lothian, MD 20711 Lawrence H. Silver/ Son other Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important: if ther
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Ft. Lincoln Crematory March 17, 2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licansee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 elbac Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Betwe Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical (ENM Examiner Due to (or as a consequence of) Physician/Medical Examiner Multi-Infarct Dementia The lew requires that the deeth certificate be executed usa as the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. Dementia Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ۵. Records, ģ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 No of Vital Physician: Medicai Certification: To Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this lunerel 28b. Time of 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 5 Pending investigation 1 Naturat s after death.

i Director: Aft
d in by the lur 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier within 24 hor To the Fune (Check only one) \$ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and titla of 2 53885 6 MD 30. Name and address of person who complete ited cause of death (Item 23a) (Type, Print) CLINTON 307 MD CAMANAN SURRATTS 7501 VENKAT. 20735 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State MAR 2 3 2000 Registrar

DHMH 16 Rav 6/95

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Edline S  4a. Facility Name (If not institution  Mariner Healt  5. Social Security Number			esda	n yrs. lest bi	irthday)	If Undar 1 Yo	Ве	Town, or Li thesd	2. Date of Death Month coation of Death a	Day 21 2 4c. County	Year QOO of Death ntgome:	-	
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10e. Street and Number						10f. Zip Coo	de		10	g. Citizen of	What Country?		
2305 Ross Ro	oad						2091	0		uni	ted Sta	ates	
11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, 2 ☑ No  If Yes, Give						Vas Decedent Yas, specify ( ☐ Yes 2)()			ecify Yas or No- Rican, atc.)		ck, White, atc.		
3 Widowed 4 □ Divorced	i	Year or C	Dates:							Specin	, Drac	S.K.	
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17. Father's Neme <i>(First, Middl</i> e, Unknown	Last)						18. Mo		a (First, Middle, M irian Fo				
19a. Informant's Name/Relations Clover Arthur			Niece	198					al Route Number, er Sprin		State, Zip Co.		
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23a. Part 1. Inter the disease, on whock or heart failure. List immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death)  Pert II. Other significant conditions.  25. Was case referred to medical examiner?  1   Yes   2   No   No   No   No   Natural   5   Pendical Pendical   Pendical   1   Pendical	b c d one contri	ations that cause on a	Due Due Inpalient	death. Do  leme to to (or as a  to (or as a  to to resulting)	22. not enter consequences	Nama and Ac 4001 E or the mode of uenca of): uenca of): deriying cause	ddress of Fac Bennin dylng, such	g Rd. as cardiac	23b. Did tot  1 Ye  24a. Was an perform	oecco use co s 25 No autopsy ed? s 2 No	Home D.C. 2 Ap Introduction On 3 Probable  24b. Were availate comply of dear 1 1 Yes	proximate enval Betwean set and Death of Cause of death?  y 4 Unknown enutopsy findings ble prior to stion of cause h?	

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Director

Completed by

29b. Signaf

**Physician** /Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Copariment of Health end Mental Hygiane.

Incorporate If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, its Medical Examinar must be notified at

Physician /Medical

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medicai

Baltimore, Maryland 21215-0020

State Registrar

29c. License number 1205/16 29d. Date signed (Month, Dey, Year)

30. Name address of person who completed cause of death (Item 23a) (Type, Print) Joel Schulman

9410 OLD GEORGETOWN RD BETHESDA, MD

31. Day filed (Month, Day, Yeer)
MAR 2 4 2000 32 Registrar's Signature

ROBERT JOSEPH WALL

JOSEPH

WALL.

SR.

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

26. 2000

2. Date of Death MARCH

4b. City, Town, or Location of Deeth

2:47 PM

Yes 2□No

Approximete Intervel Between Onset and Death

hick

Rural Route Number,

		1. Decedent's Ner	ne (First, Middle, Last)
1	Physician /Medical	ROBE	RT JOSE
	Examiner		(If not institution, give s LOCK OF PO
	Funeral Director	5. Social Security 218-68-	- X
	D	Usuel Residence	of Decedent
	ylan	10a. State	10b. County
	Mart at	MD	Charle
	or 28	10e. Street and N	umber
	th with the state of the state	1013 W	iltshire
5-0020	72 hours after death with the Maryland natural; or items 23s or 28s-f show deat Exercise and Director	11. Marital Status 1 Never Ma 3 Widowed	
15-0	natural and a second	(Spe	15. Decedent's Educe ecify only highest grede

Completed

pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Nem 27 Is marked other than "n any Injury or other traumatic event. The management of the **Physician** /Medical **Examiner** 

Baltimore, Maryland 21215-0

Box 68760

P.0.

Division of Vital Records,

Examiner sician and burial-transit ettending physician for use as the buria certificate be Physician/Medical the signed by by 8 Completed After this certificate hes Be 2 Medical Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

4c. County of Death a Facility Name (If not institution, give street end number) RIPLEY CHARLES 8100 BLOCK OF POORHOUSE ROAD if Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Months Days Hours December 6, . Social Security Number 9. Birthplace (State or Foreign 1957 Maryland 7. Age (In yrs. last birthday) 6. Sex 10 M 2□ F Months 42 Yrs. 18-68-2436 Jsuel Residence of Decedent Oa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Charles La Plata Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20646 1013 Wiltshire Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Pace - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Gollege (1-4or 5+) US Govt. Director 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Richard David Wall, Sr. Ann Gerlach Wall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 9224 Route 99 Ellicott City,MD 21042 Ann Wall/Mother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gar. 4/1/00 Waldorf, MD. 4 ☐ Donetton 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) wis to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yee 2 No 3 Probably 42 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? -2 No 25. Was cese referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence XX Other (Specify) AT, SCENE XX Yes 2 □ No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Naturel 2. Accident 2 45 Pm 5 Pending Investigation 3/26/00 1 Yes

State Registrar

28e. Plece of Injury - At home, lerm, street, factory, office building, etc. (Specify)

Acothera.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year) MARCH 27, 2000

ccich

Location (Street and Number of City or Town, Stete)

30. Name and address of person who completed ceuse of perth (Item 23a) (Type, Print) ITEODORE MIKE

6 ☐ Could not be

MAR 2 9 2000

3 ☐ Suicide

29e. Certifier

4 Homicide

29b. Signature end title of certifier

31. Date filed (Month, Dey, Year)

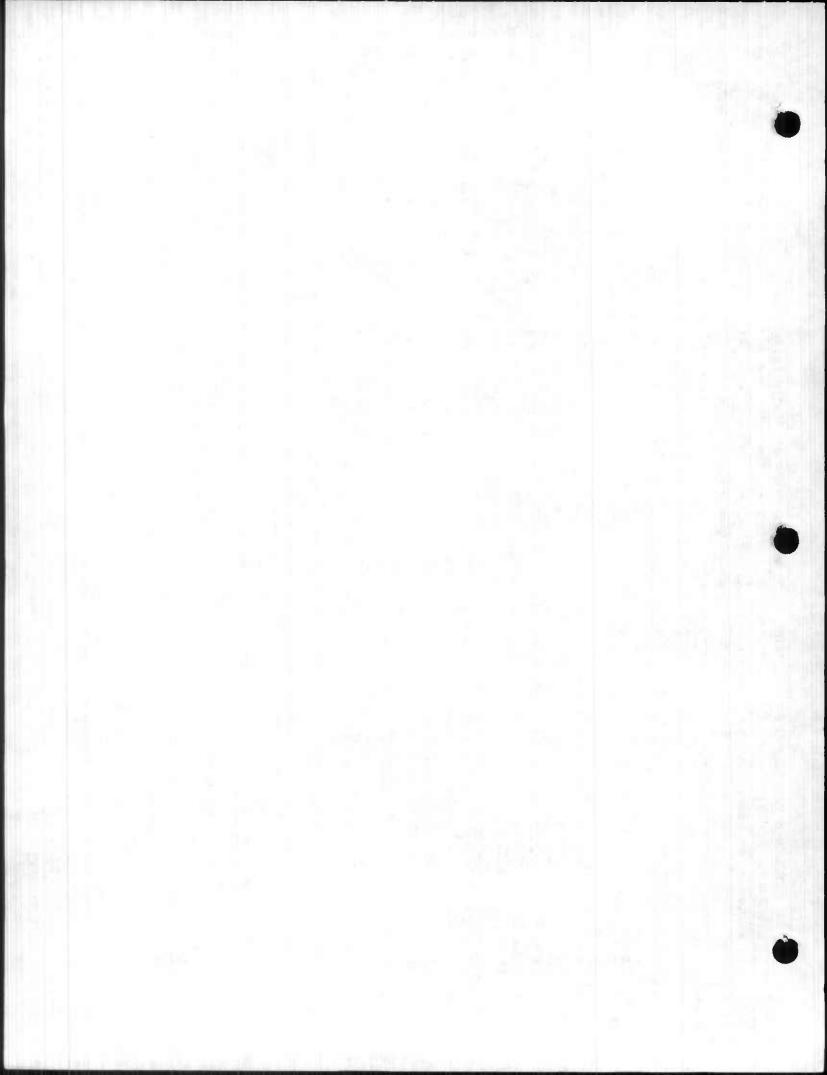
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E

32. Registrer's Signature

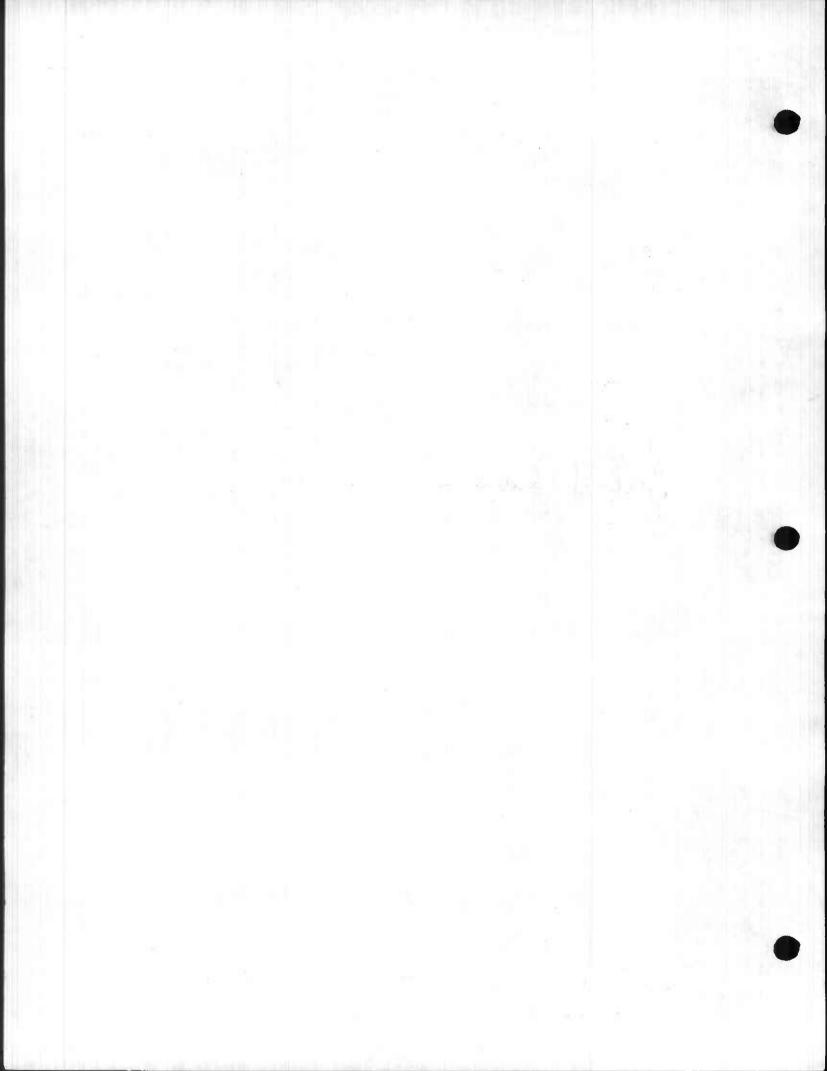
parks



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WEAVER JACK D. 27, 2000 March 7:22 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince George's H Under 24 Hrs. 8. Date of Birth Hours Min. Worth, Pay, July 4, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 100 M 2□ F 180-28-2489 63 Director Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10s. State 10c. City. Town or Location 10d, Inside City Limits show 1 Yes 2 No Directo Waldorf Maryland Charles 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be r 5205 Tattler Court U.S.A. 20603 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (1) Yes 2 □ No 1954 – If Yes, Give Year or Dates: 1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 1958 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Inspector World Airways Pages 1 and 2 should be flied w timent of Health and Mertal Hygie famt: If Nem 27 le marked other ti glury or other traumatic avent, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Lahman Ortha Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia C. Weaver/Wife 5205 Tattler Court, Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) of Disp 20c. Location - City or Town, State 1 1 Bural 2 DCremation 3 □ Removal from State Department of important: if any injury or once. nation 5 Other (Se 4 Denation Maryland Veterans' Cem. 03-31-2000 Cheltenham, Maryland 21. Sim The Huntt Funeral Home, Inc. MARK & M00053 P.O. Box 156, Waldorf, Maryland 20604 mew Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** RESPIRATORY Immediate Cause (Finel disease or condition resulting in death) /Medical ALURE Examiner quence of): Physician/Medical Examiner BRONCHOGENIC CARCINOMA The law requires that the death certificate be assecuted the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Due to (or as a consequence of): for usa as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached 1 Yes 2 No 3 Probably 4 Unknown ARTERY Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed cartificata has 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Stinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After To the Funeral Director: After To the Funeral Directors of the Funeral Directors of the Funeral Director of t 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Contribute Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 I Medical Exercision: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 29c. License number 53885 MI 7100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #307 CLINTON MD SURRATTS 20735 7501 KAMAWAN VENKAT. KOAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 29 2000 Registrar



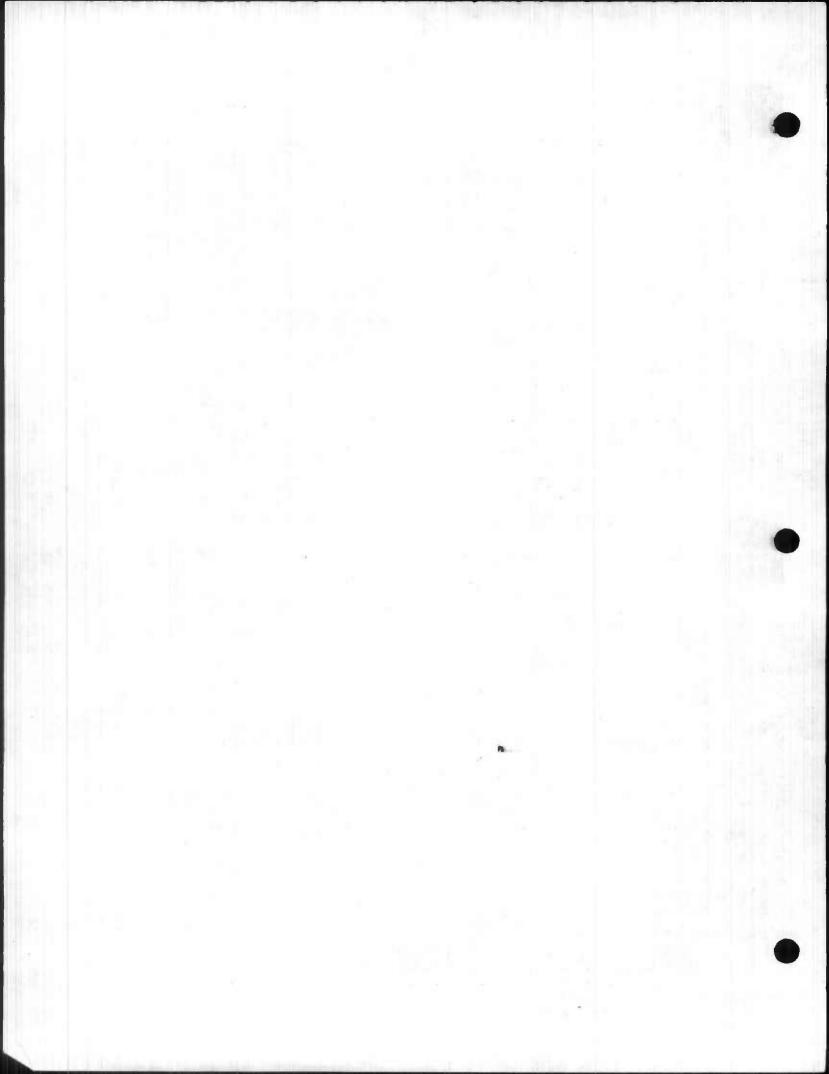
# William Willetts, Jr

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Director	10e. Street and Nu					10f. Zip Code					10g. Citizen of What Country?		
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DHMH 16 Rev 6/95

G. Sparker



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent'a Neme (First, Middle, Last) 3. Time of Death Month Physician **Gladstone** Bailey Adams, Jr. April 6, 2000 2:59 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Nursing Center Baltimore County Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1 □M 2 □ F Yrs. 213-20-3888 75 Director February 11,1925 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland 1 Yes 2√ No Baltimore Towson 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ā 615 St. Francis Road U.S.A. 21286 Funeral Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yr's Foreman Tool & Die Maker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Gladstone В. Adams Dorothea M. Litchfield 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Evelyn A. Adams - Wife 615 St. Francis Road Towson, Maryland altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete etery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 4/10/00 BalTIMORE, Md. 21. Signeluranof Funerel Service Licensee Paul L. Hartsock, Jr. 22. Name end Address of Fecility Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 5305 Harford Rd. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thal initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Completed by Phyaiclan/Medical the Due to (or es a consequence of) for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Nother (Specify) 10 S / 10 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural death. 1 Yes 2 No 2 Accident after deatl Director: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral Dicompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifies 29d. Dele signed (Month, Dey, Year) uno 25205 Mohmis April 6, 2000 30. Name and address of person who completed sauge of death (Item 23a) (Type, Print)

W-A-R(RY G-BMC 670) Nles St. Balto and 2120x

State Registrar

**DHMH 16 Rev 6/95** 

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State 31. Date liked (Month, Day, Year) APR 1 0 2000

22. Registrar's Signature

Sparke



SASA ALEKSIC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** 7, Sasa APRIL 2000 0028 AM Aleksic /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner GUILFORD & 29TH STREET. BALTIMORE If Under 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1X0 M 2□ F Months 30 Yrs 21, 1970 Yugoslavia Director 218-53-1751 Usual Rasidanca of Dacedant 10c. City, Town or Location 10d. Insida City Limits the Marylan 10a. Stata 10b. County 28a-f show 1 Yes 2 No Directo Yugoslavia Belgrade 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 6 mut be Lazarevacki Drum #17 11000 Berns 23a Yuqoslavia Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yas 2 XNo If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, 11 Marital Status i Hygiere. d'Hygiere. other than "natural", or ham Black, Whita, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à White 3 Widowed 4 Divorced Year or Datas Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 5+ Medical Doctor Hospital permit. Pages 1 and 2 should be files
Department of Health and Mentai Hyg
important: if Iben 27 is marked other
any Injury or other traument. 17. Fathar's Nama (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumema) Be Darinka Ilija Aleksic Kosic 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Stevcic-Besir - Sister Ruzica Lazarevacki Drum #17 Belgrade, Yugoslavia 11000 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Surial 2 □ Cramation 3 □ Ramoval Irom Stata 4 ☐ Donation 5 ☐ Other (Specify) 4/15/2000Belgrade. Yugoslavia Novo Groblje 21. Signature of Funaral Sarvice Licansee Paul L. Hartsock, Jr. 22. Nama and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause of the line. Approximate Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) /Medical Examiner Examine physician and s the burial-transit certificate be axecuted Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated avents resulting in deeth) Last Dua to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequance of). 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 6 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evailable prior to 24a. Wes an sutopsy performed? Completed completion of causa of deeth? eced 1 Yas 2 No 1 Yas 2 No certificate of Vital 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospitel: Othar: 4 Nursing Homa 5 Rasidence XXOthar (Specify) AT SCENE 1XX as 2 No edical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28b. Tima ol Injury 28d. Dascribe how injury occurred 27. Mannar of Death 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funera Division 5 Panding investigation 1 Neturel motor vehicle collision 1 Yas 2 No 4-7-00 0013AM 2 Accident 6 Could not be detarmined 3 ☐ Suicida 281. Location (Straat and Number or Rural Route Number, City or Town, Stele) Guil Ford X 29 55 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida speet Balbown. Nel Certifying Physician: To the best of my knowledge, death occurred at the time, deta end plece, and due to the cause(s) and manner as stated.

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\*\*Comparison of the cause (s) and manner as stated (s) and ma 29a. Certifier (Check only one) 29b. Signatura and titla of cartilia 29c. Licensa number 29d. Data signed (Month, Day, Year) O.C.M.E 7, 2000 APRIL bruken Wenne 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) lennis 111 Penn Street, Baltimore, Maryland 21201 hute m Year 32. Registrar's Signatura 31. Date liled (Month

State Registrar

**DHMH 16 Rev 6/95** 

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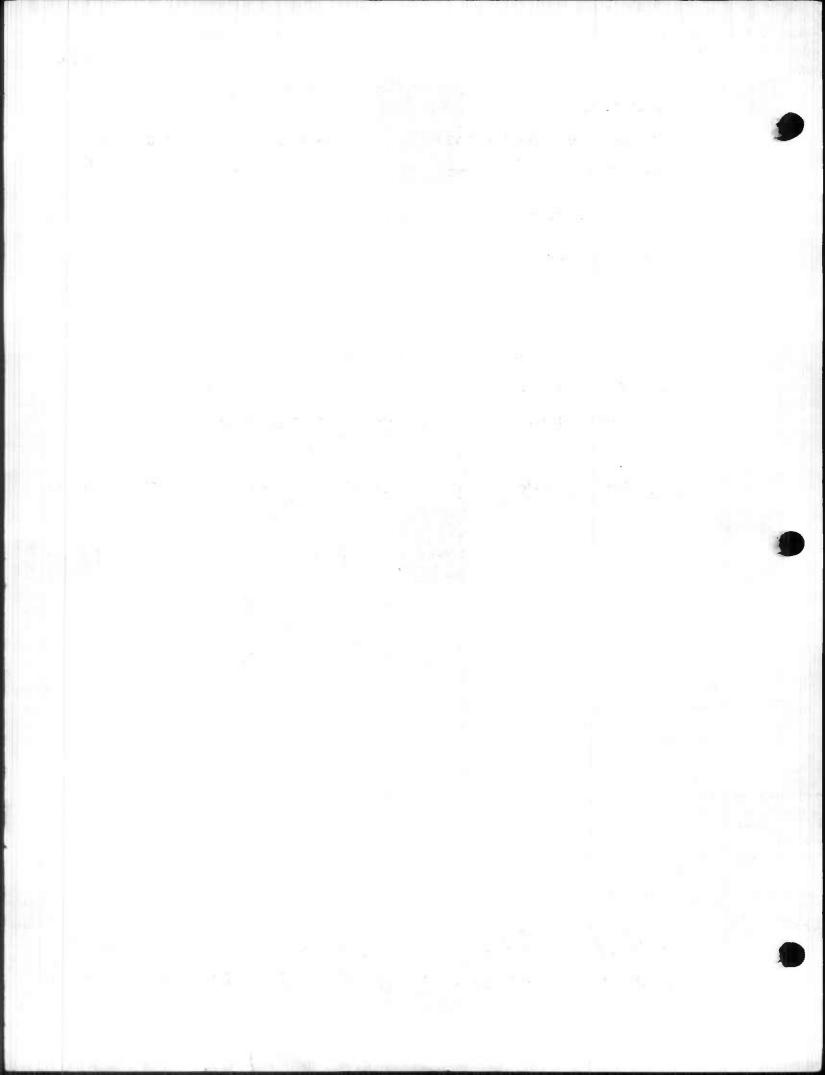






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Z See	Funeral Director	10e. Street and Number					10f. Zlp	Code			10g. Citizen of What Country?			
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	ner	11. Marital Status		12. Was Dece Armed For	dent Ever in	U,S. 1	3. Was Deced	dent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N		Race - American Indian,     Black, White, etc.		l,
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permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical and To Be Completed.		9 none secretary							T	shipping				
	Be	17. Father's Name (First, Mi							18. Mother's Nam			am <i>e)</i>		
	10	Richard A.				T				ma F. H				
		19a. informant's Name/Rela Julius Anders							and Numberor Rui an City,			m, State, Zij	o Code)	
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		30. Name and address of pe	rean who	completed cause	//	tem 23a) (Typ	oe, Print)	Cha	5205 Wes H. 1	Bulto	md	515	20	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death ANNA E. BIDEN Month **Physician** 8, April 2000 6:08 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of North Arundel Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) May 7, 1910 9. Birthplece (State or Foreign **Funeral** Deys Hours 1□ M 2□ F 216-24-0896 89 Vrs Pennsylvania Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show 28a-f show Anne Arundel Pasadena Maryland 1 □ Yas 2 N No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 711 204th Street 21122 USA 238 "natural", or Items 23s Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: If itsm 27 is marked other than "natural", or its any injury or other traumatic evant, trained other practice. 1 Yas 2 No If Yes, Give Yaer or Datas: 1 Navar Married 2 Merrled Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: P 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Housewife 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Andrew Gersev Josephine 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Anna E. Weber (Daughter) 3536 Seventh St., Baltimore, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Crametion 3 ☐ Removel from Stete 4/11/00 Mt. Olivet Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fanarel Service Licensee Kevin E. 22. Name and Address of Facility Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final wws disaese or condition rasulting in deeth) Examiner Examiner hours bunial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) P.O. Box 68760, physician s the buna Physician/Medical Dua to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Vunknown Records. þ Completed 24b. Ware autopsy findings available prior to heart failur 24a. Wes en eutopsy performed? completion of cause of death? 25. Was case referred to medical examiner? 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attanding Physician: 26. Piace of Deeth (Check only one) Hospitel: edical Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 1 Neturel 5 Pending To the Hospital or Attanging within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifies 29d. Date signed (Month, Dey, Year) 29c. Licensa number April 10, 2000 D-40521

State Registrar

**DHMH 16 Rev 6/95** 

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31. Date filed (Month, Day, Year)

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32. Registrer's Signeture

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

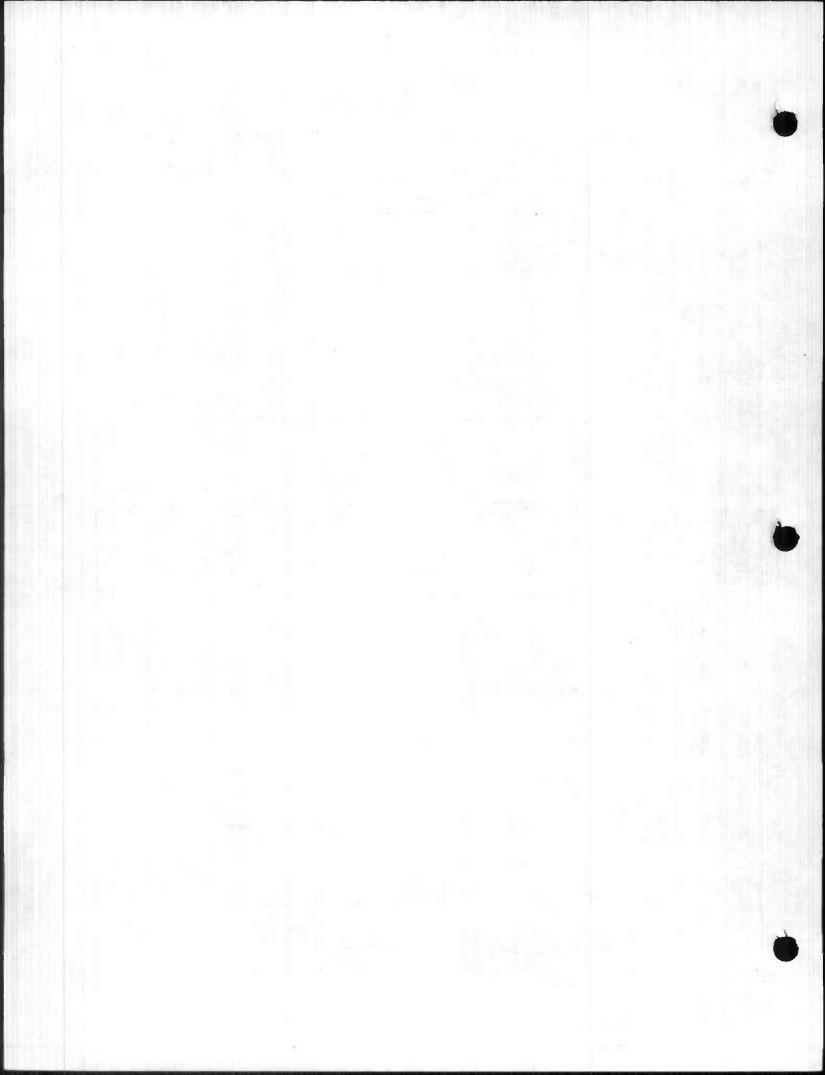
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Neme (First, Middle, Last) 2. Dete of Deeth 617 **Physician** 5,2000 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Dealt Examiner MARYLAND Baltimore If Under 24 Hrs. If Under 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign **Funeral** Months Days Hours 1 M 20 F Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director laryland mor 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 6  $\propto$ . Wes Decedent Ever in U,S Armed Forces? 14. Race - Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indien, 11 Meritel Status Black, White, etc. 1 Never Merried 1 X Yes 2 ☐ No If Yes, Give 2 Merried 1 Yes 2 No Applicity: Specify: Completed by 3 Widowed 4 Divorced Yeer or Detes: Hmerica 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Important: if Nem 27 is marked other than any injury or other Elementery/Secondery (0-12) College (1-4or 5+) Balto. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme Be 8 Pages 1 and 2 should nent of Health and Men 2 19e. Informent's Newe/Reletionship (Type, Print) (SISTET 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Janic Ma Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Method of Disposition Dave 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 ☐Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) emeter 2000 22. Name end Address of Facility 21. Signature of Funerel Service Licenses Joseph S Nor th Ave Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death 23a. Pant. Physician /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by page 2 should be detact 3 Probably 4 Unknown 1 Yss 2 No ģ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24e. Wes en eutopsy performed? 1 Yes 2PINO 1 ∏ Yes 2 ∏ No this certificate or Attending Physician: director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Yes 1 2 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, dete end placa, and due to the cause(s) end menner steted. edicai 29a, Certifier ş 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 10

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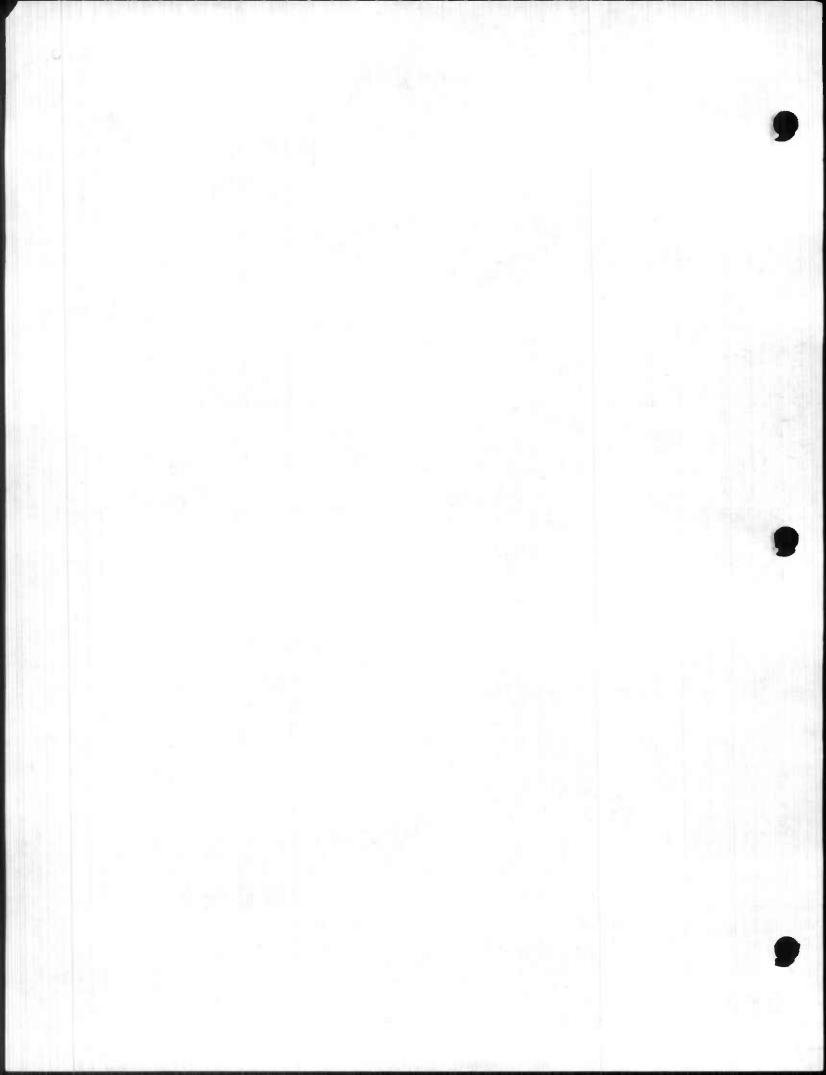
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31. Dete filed (Month, Dey, Year) APR 1 0

32, Registrer's Signeture

pleted cause of deeth (Item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** owr 2000 /Medical 4c. County of Death 4b, City, Town, or Location of Deeth Facility Name (If not institution, give street end number) Examiner OWY If Under 24 Hrs If Under 1 Year 7. Ale (In yrs. last birthdey) 6. Sex 8. Birthplece (State or Foreign Quantry) **Funeral** Days Months 1⊠M 2□ F Yrs Director Usuel Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or items 23s or 28s-f ahow any Injury or other traumatic avant, in Mades E. 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 15 Yes 2 No Funeral Director mor Maryland 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S Armed Forces? 11. Meritel Status Bleck, White, etc. 1 Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Merried 2 No 1 Yes 2 No Specify by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO|NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) zenera 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be 2 Ioma 6 19a Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address-(Street end Number or Rural Route Number (wife 20b. Plece of Disposition (Neme of cametes), cremetory or other plece) 20e. Method of Disposition City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Louisee 22. Name end Address of Facility oseph 222 12/6 Nor th , or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Causa (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of) physician s the burial Box 68760. Physician/Medical Due to (or es e consequence of): for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No signed b Ą 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed paga 2 has 1 Tes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier (Check only onel To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cert ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who co enan

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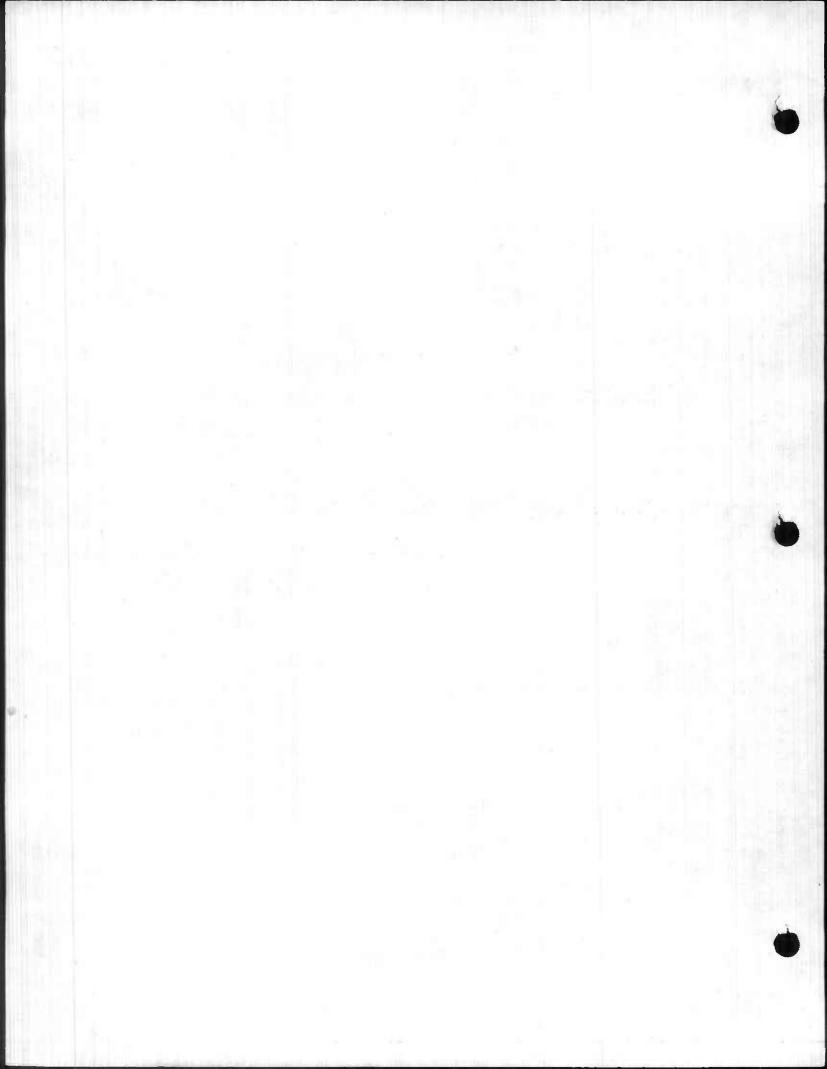
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32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth A Month **Physician** 0 /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner nor 6. Sex 10 M 2 F yrs. lest bir If Under Dete of Birth Month, Dey, 9. Birthplece (State or Foreign 5. Sociel Security Number Age (In nday) **Funeral** Days Months Hours Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiena. Important: If Nem 27 Is marked other than "natural", or Neme 23e or 28e4 ahow any injury or other tranmatic avent, his Medical Estimation man be notified as 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Nos 2 No Director MOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 3altimore, Maryland 21215-0020 1□Yes 2XNo Specify: by Specify. 3 Widowed 4 Divorced Completed Ith and Mental Hygiena.
If is marked other than "nature traumetic avent, the Medical. 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 10 6 19a. Informant's Neme/Reletjonship (Type, Print), (daughter) 19b. Meiling Address (Street end Number or Rural-Route Number 20b. Place of Disposition (Name of cametery, crematory or other place) Dare 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removei from Stete 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22 Name end Address of Facility Home ray oseph Nor Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory or heart failure. List only one cause on each line. Approximete interval Between Onset and Death 23a. Parti. **Physician** (archiovanalar Dixado End stage HTKensclendice /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner otage Rena the burial-transit The law requires that the death certificate be executed Due to (or a consequenca of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest P.O. Box 68760, Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 Probably 4 DUnknown should be deta Records, Be Completed by 24b. Were eutopsy findings available prior to competion of cause 24a. Wes en autopsy performed? of death? 1 Yes 1 Yes 2 No cartificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 2/5 ER/Outpatient 3□ DOA 1 Inpatient Aftar this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Naturel within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 Yes 2 No completely filled in by the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner steted. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 4 (lame 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Eutaw St. #308 Baito. md. 21201 Sabapathi 821 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Ray 6/95** 

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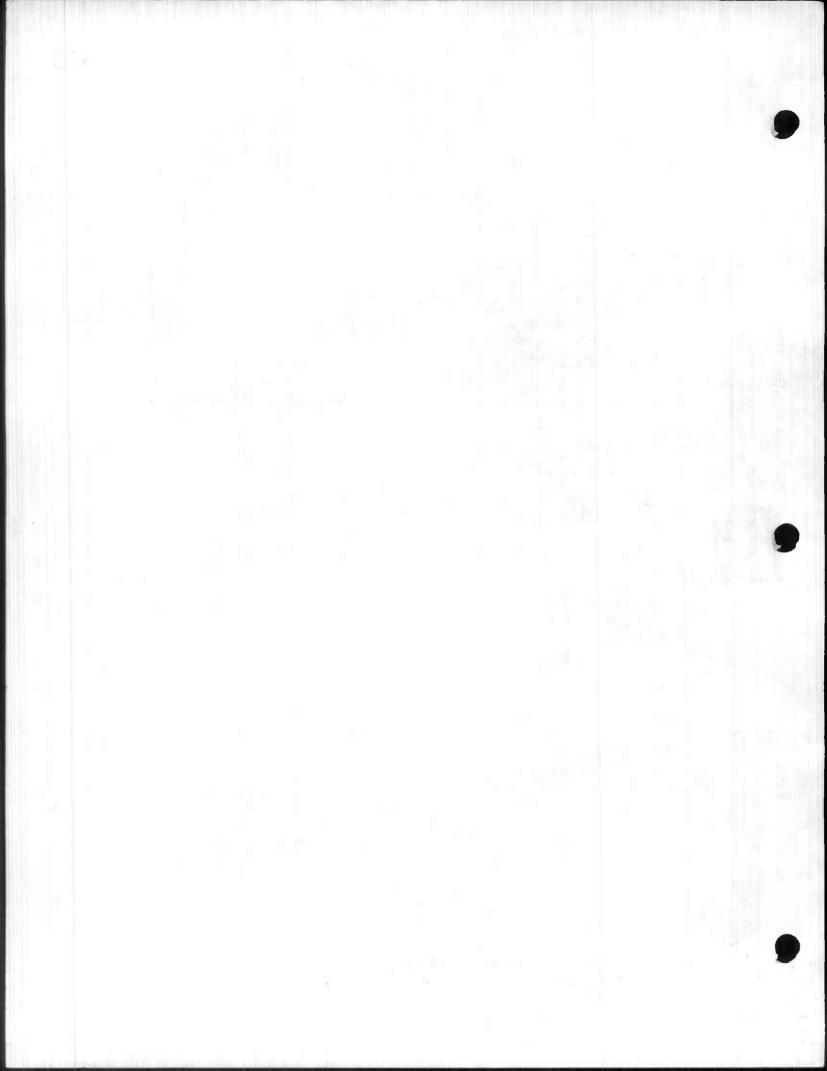
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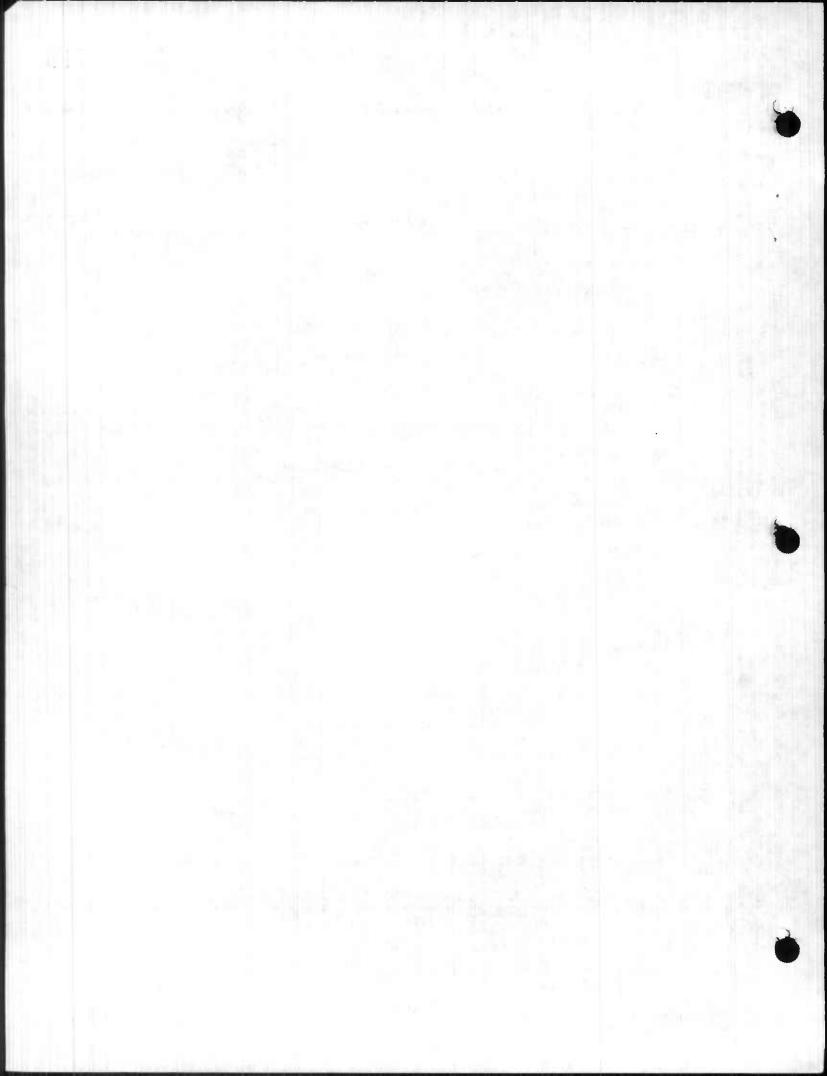
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8, 2000 9:45PM F. Browne, Jr. William April /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1MM 2□ F Yrs. 85 New York Director 052-12-5142 Feb. 3,1915 Usual Residence of Decedent death with the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f show idical Examiner must be notified at 1 Tyas 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane STT11 21228 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Hedest Exercises once. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5+ Surgeon Medical 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William F. Browne, Sr. Dorothy Rose 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 1905 Broadway Road Brian J. Browne/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 14/12/00 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. thomas uante 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part1 anter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical Pre-monia Hspiration hours Examiner Due to (or as e consequence of): Physician/Medical Examiner Levi Stroke sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): signed by the aid be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Qunknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Surring Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medicai Certification: To this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident aftar death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 2 UND 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliatt Choile lago Hrose H LAZIIS 711 Maider 31. Date filed (Month, Day, Year) 32. Registrer's Signature State APR 1 0 souks 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene 1

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Physicia /Medic	an	Rona	nst, Middle, Ca	Brook	S					Month APRIL	Dey 06	Year 2000	22:35
Examine	er <sup>4</sup>	la Facility Name (If no 201 SAINT N							own, or L LTIM	ocation of Death ORE	4c. Count	y of Death A	
Funeral Director		5. Social Security Num 214-62-9		Sex 7. Age	(In yrs. les	st birthdey) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Birth (Month, Dey 12-07-	Year) -54	Coun	place (State or Foreigntry) MD
2	-	Usual Residence of De			100 000	Town as Las	-11						Od Incide Ob. I leike
death with the Maryland rms 23a or 28a-1 ahow rms 11a notified at	Director	10a. State   10b. County   10c. City, Town or Location   MD   NA   Baltimore									Od. Inside City Limits  X → Yas 2 □ No		
r 28	i e	10e. Street and Number	er .				10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
38 c		201 St.	Matth	ews Stree	t		212	02			US	A	
urs after al', or its Exempts by Full	uner	1 t . Merital Status 1 ☐ Never Merried		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N	var in U,S.	13. W	es Decedent o Yes, specify C	f Hispanic Or uban, Maxice	rigin? (Sp on, Puerto	pecify Yes or No- Rican, etc.)		ce - Amaric ick, White,	
		3 Widowed 4		If Yas, Give Yeer or Detes:		1	□ Yes 2□M	lo Specify	:		Speci	fy: B	lack
			15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working							16b. Kind of E	Business/Inc	dustry	
hin 7.	Completed	(Specify	-	ade completed)  College (1-4or 5	4)	(Give kind of work done during most of working lifa. DO NOT use retired)							
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Aenta Aenta rked tice	0	Herbert	L. 1	Wallace,	Sr.		Part.	Tr	ella	a M.	Mc	Knig	ht
and la		19a. Informent's Ne <i>me/</i> Reletionship ( <i>Type, Print</i> )  19b. Meiling Address ( <i>Street end Number or land)</i>							per or Rui	ral Routa Numbe	r, City or Town	, Stete, Zip	Code) 21202
and saith		Trella	M. Wa	llace		201	St. M	atthe	WS S	Street	Balti	more	,Marylan
T to		20a. Method of Disposition  20b. Place of Disposition (Neme of cemetery, cremetory or other place)  20b. Place of Disposition (Neme of cemetery, cremetory or other place)							Data	20c. Location	- City or To	own, Stete MD .	
Pag int: II	-1	4 Donetion 5			Gar	risor	Fore	st VA	Cer	m. 04-1	0-200	O Ow	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any Injury or other fraumatic event, the Max DDCs.		4 Donetion 5 Other (Specify) Garrison Forest VA Cem. 04-10-2000  21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Mary								ylan	d 21202		
40244		N N	adus		nen					101 E.N		Aven	
Physician		23a. Pert1. Enter the c shock, or heert fa	diseese, or con ailure. List only	plications that caused one cause on each lin	the deeth.	Do not ente	r the mode of o	tying, such e	s cerdiac	or respiratory ar	rest,	1	Approximete Intervel Batween Onset and Death
/Medical Examiner		Immediate Ceuse (Fin disaese or condition	al	HYPE	RTENS	IVE C	ARDIOVA	SCULAR	DIS	EASE		1	
Saffing.	Jer	resulting in deeth)  Due to (or es e consequence of):									1		
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sicla bur	Cal	thet initieted events	ary .	C	Due to for e	IDAGOOO A SE	ance off:					+	

Physician/Medi Be Completed by Medical Certification: To

4 Homicide

29b. Signeture end title of certifie

y the a 2

resulting In death) Last

23b. Did tobacco use contribute to the cause of death?

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown MORBID OBESITY 24a. Wes an autopsy performed? 102 Yes 2 □ No

24b. Were autopsy findings evailable prior to completion of ceuse of death? 1KLYes 2□ No

APRIL 7, 2000

25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3D DOA 28c. Injury et Work? 27. Menner of Deet 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1) Neturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29d. Dete signed (Month, Dey, Year) 29c. License number O.C.M.E.

30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

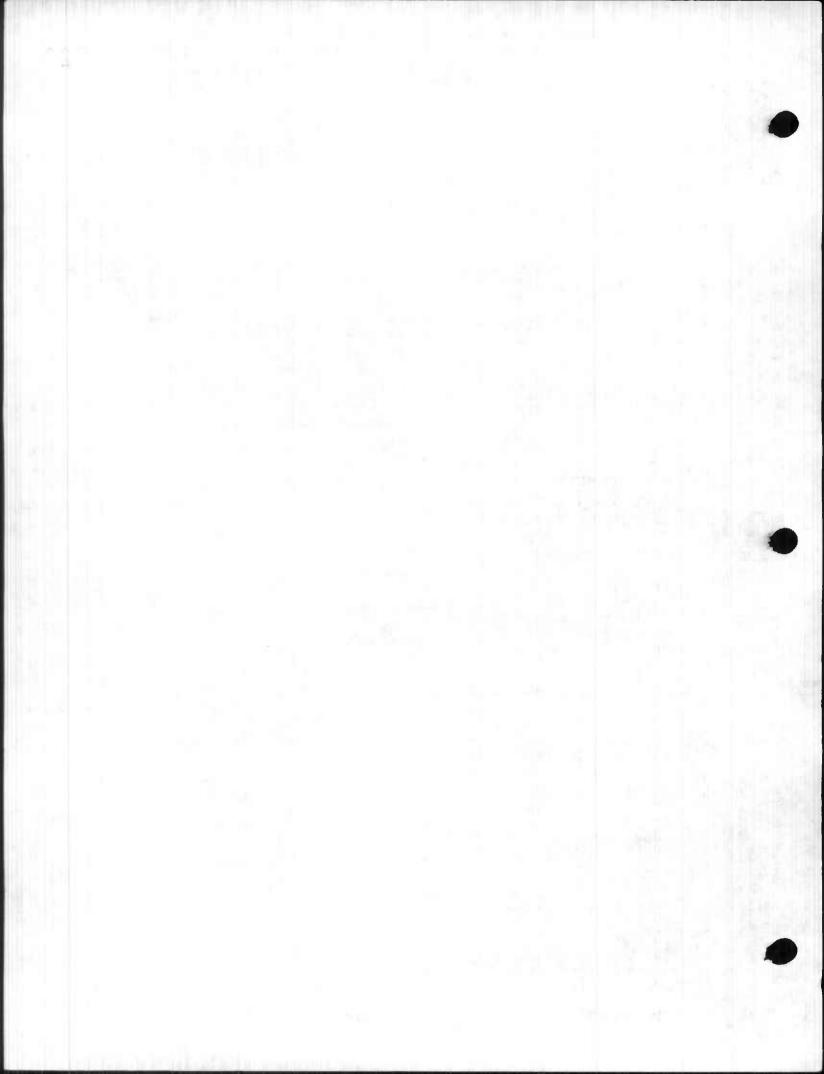
111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Month, Dey, Year) APR 10 ZUUU

ntemo 32. Registrer's Signa

Division of Vital Records, P.O. Box 68

To the Hospital or Attending Physician: within 24 hours after death.



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Vaai ·25 pm KENNETH THOMAS BROOKS 2000 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Be / h No. | Birth | Hours | Min. | Month, Day, Year) N/A Medical 5. Social Sacurity Number Birthplaca (State or Foraign Country) 7. Aga (In yrs. last birthday) Months 1₩ M 2□ F N/A Yrs 3-24-2000 MD Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No GLEN BURNIE BALTIMORE MD. 10f. Zip Coda 10g. Citizan of What Country? 10e Street and Number 306 CONGRESSIONAL CT. 21061 USA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Yas 2 No 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) Elemantary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) KENNETH BROOKS KIMBERLY ROGERS 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH BROOKS (FATHER) 306 CONGRESSIONAL CT. GLEN BURNIE, MD. 21061 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata SMALLS CEMETERY 4-9-2000 ROPER, NORTH CAROLINA Othar (Specify) 4 Donation 22. Name and Address of Facility ice License PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such es cardiac or respiratory arrast, or haart failure. List only one cause on each line. Approximate Intarval Batween Onsat end Deeth Immadiata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or Injury thet Initieted avents resulting In deeth) Last Dua lo (or as consequance ot) 215 Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yas 2 No 25. Wes casa referred to medical axaminar? 28. Piece of Deeth (Check only ona) Hospital: Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Mannar of Deeth 28b. Tima of 28d. Describe how injury occurred 28e. Data of tnjury (Month, Day 28c. Injury et Work? 5 Pending Invastigation 1 Yes 2 No 2 Accidant 6 Could not be datarminad 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the tima, data end piece, and dua to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date end piece, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

Examiner Records, P.O. Box 68760 Rogers f or Attend efter death Director: / To the within 2

> State Registrar

**Physician** 

\* /Medical

**Examiner** 

Director

Funeral

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Completed

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Examiner

Physician/Medicai

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Completed

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To

Certification:

Medical

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notilled at

Pages 1 end 2 should be filled within nent of Health end Mental Hygiene. Int: If item 27 is marked other than "Inty or other traumatic event, me Men

**Physician** /Medical

sician and buriel-transit

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ettending physician

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signed by t

certificate has

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24 hours

director,

funeral

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) 2000

ees of person

29b. Signature

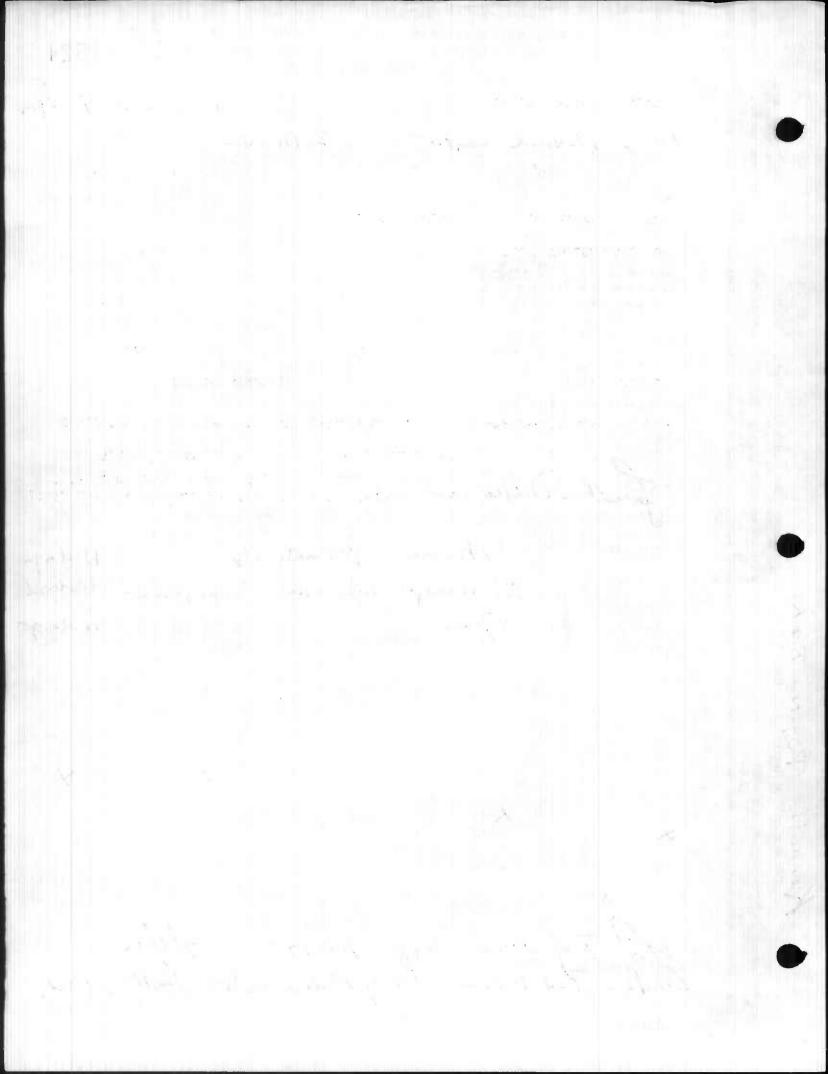
32. Registrar's Signature

o completed cause of deeth (Item 23

Print)

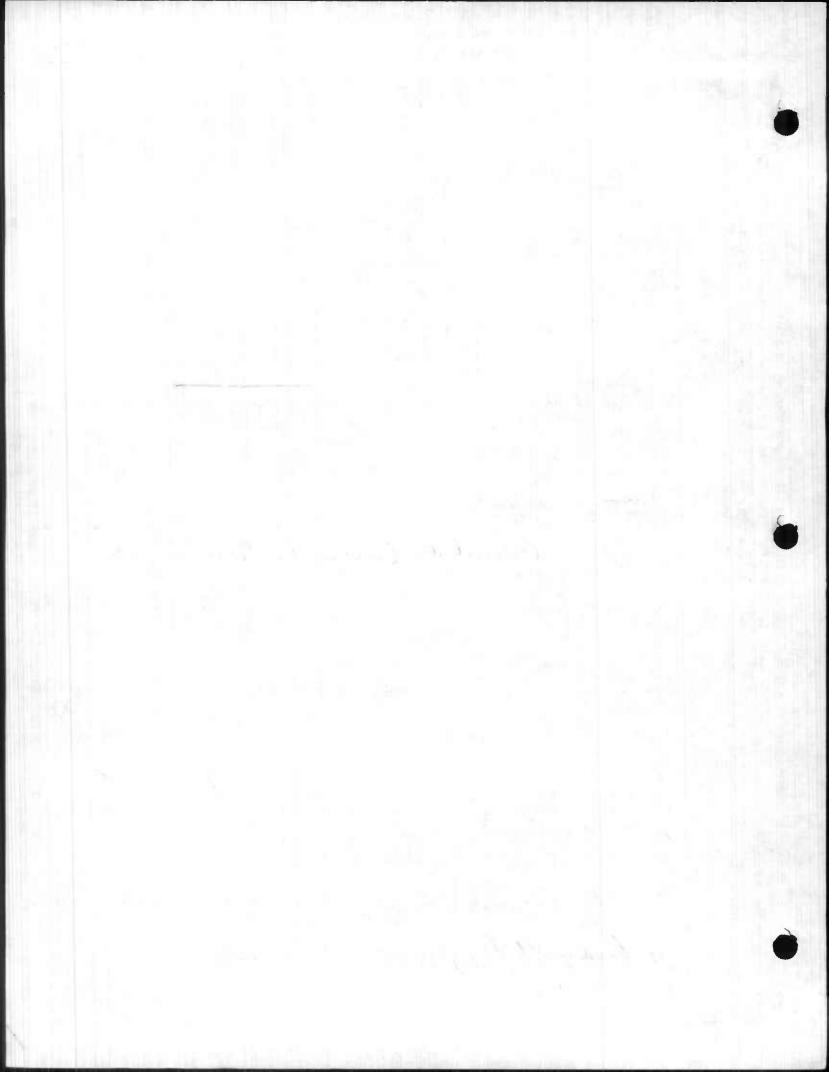
29c. License numbe

29d Digte sigglid (Month: Day, Year)



State of Maryland / Department of Health and Mental Hygiene 00 11522

	PER FH G782 4/18/2000 AF 1. Decedent's Name (First, Middla, Las			Certificate of		2. Date of Dea		Year	3. Time of Death			
Physician /Medical	Michael Andrew Ca	rter					04° 200	00	10:26 P.M			
Examiner	4a Facility Name (# not institution, give Northwest Hospita				4b. City, Town, or to Randalls		4c. County	of Death	ro			
			yrs. last birth	dayl If Under 1 Year		8. Date of Birth						
Funeral Director	009-32-4058 Usual Residence of Decedent	7. Age (In	Yrs. last birth	Months Davs	Hours Min.	(Month, Day	Year) 1946		lace (State or Foreign try) York			
1	10a. State 10b. County	100	c. City, Town	or Location				11	0d. Inside City Limits			
a notified at	MD Baltimo	re	Randa1	1stown					1 ☐ Yes 2 🖾 No			
S S	10e. Street and Number			10f. Zip Code		1	0g. Citizan of \	What Coun	itry?			
ral	9906 Oakglen Roa			21133		U.S.A.						
by Funeral Director	11. Marital Status  1 Never Married	12. Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yas, Giva	in U,S.	13. Was Decedent of If Yes, specify Cul		17 (Specify Yes or No- Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  White  Specify:						
Q D	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 [	Decedent's Usual Occu	pation		16b. Kind of B		duetn/			
plete	(Specify only highast gra	de completed)	104. 0	Giva kind of work done life. DO NOT use retin	e during most of wor	king	Health					
E	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Phy	sical Ther	apist		110011					
The strong of the strong or strong o	17. Fathar's Name (First, Middle, Last)  18. Mothar's Name (First, Middle, Maiden Sumame BERNICI							re) CE.E. (	OOWLES			
	Val Carter Pamela M. Garter								00112120			
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Pamela M. Carter (Wife)  9906 Oakglen Road, Randallstown, MD 21133											
	20a. Method of Disposition  1 ☐ Burial 25 ☐ Cramation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)											
once.		21. Signature of Funeral Service Licensee  22. Nama and Address of Facility Loring Byers Funeral 8728 Liberty Road, Randallstown, MD										
	23s. Party Enter the disease, or com-	plications that caused the	death Do no					MD Z	Approximate			
as the bural-transit	Immediate Cause (Final disease or condition resulting in death)  a. Attractic (and is no cult of the consequence of):  Due to (or as a consequence of):  b. Due to (or as a consequence of):  if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
		d			Ma 2.5.							
pleted by Physician/N	Part fl. Other significant conditions of	ontributing to death but no	t resulting In t	he underlying cause g	iven in Part I.	23b. Did tobacco use contribute to the cau			1 .			
Y P						101	′es 2□ No	3   1101	Salary Salarion			
Be Completed by Physician/M		AEEF'	1635			24a. Was a perfor	n autopsy med?	av	ere autopsy findings allable prior to mpletion of cause death?			
L L						11K1	es 2 No	1,8	Des 2□ No			
0	25. Was case referred to medical				26. Place of Dea	th (Check only or						
0	examiner? 1 Yes 2 No	Hospital: 1   Inpatiant	2 ER/Outp	patient 3 DOA	ther:	loma 5 Resid		er (Specif	y)			
ation:	27. Manner of Death  1 PNatural 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Tir	ury W	ury at ork? ] Yes 2   No	28d. Describe h	ow injury occur	red				
ertific	3 Suicide 4 Homicide  8 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Farm, street, factory, office building, etc.)											
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier  29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Me	29b. Signature and title of certifier	1116			o.C.M.E.		29d. Date signe April 0					
X	30. Name and address of person who	V	) 1 (T		Street B	al tramerae	Marra	nd 1	1201			
Cinic	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	111 Penn S	orreer, B	п с шюте,	, Mary L	dila 2	1701			
State Registrar	APR 1 0 2000	Dener /		parks								

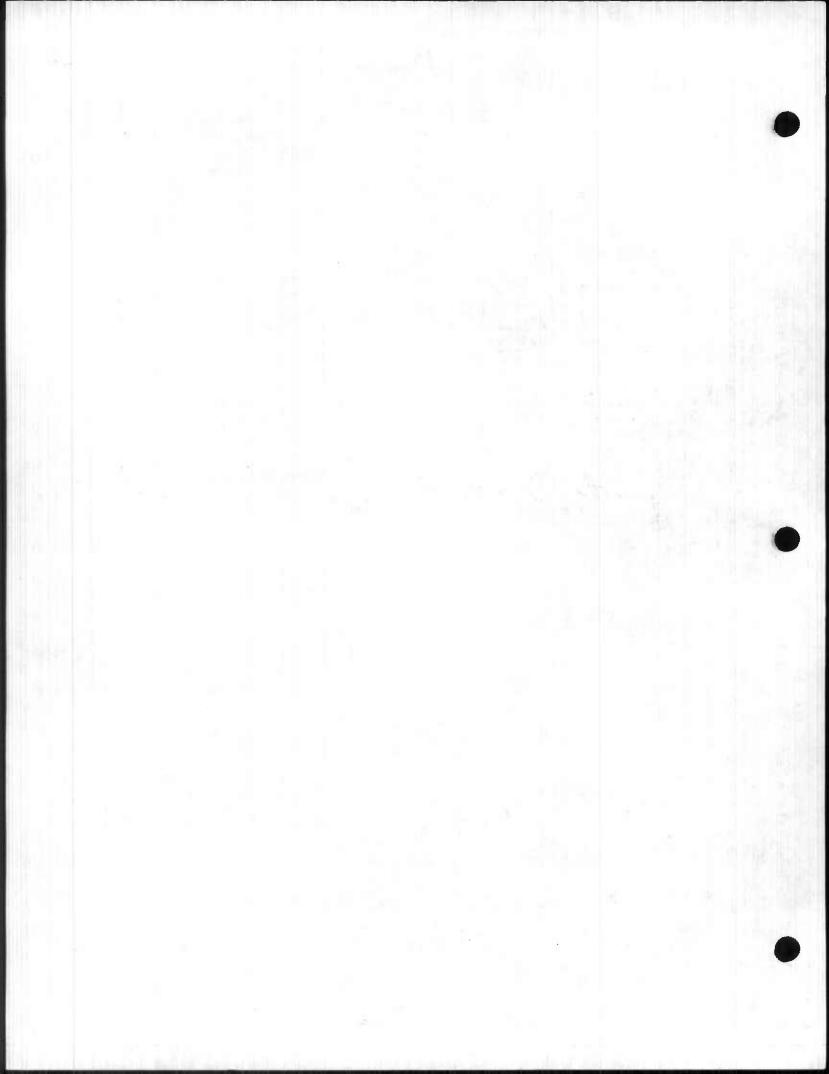


State of Maryland / Department of Health and Mental Hygiene 1

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Year **Physician** LAWRENCE EDWARD COLES APRIL 6, 2000 1:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 8-16-1921 Birthplece (State or Foreign Country)

WV **Funeral** Months Days Hours 1 M 2 F 233-34-8610 78 Yes Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director BALTIMORE TOWSON 288-1 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Name 23a or iner must be 408 FAIRMOUNT AVE. 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 72 hours after t∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried "natural", or I 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK 4 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hypiens. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event Be LAWRENCE E. COLES LOTTIE COLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 FAIRMOUNT AVE. TOWSON, MARYLAND 21286 BURNADETTE WHITE (DAUGHTER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Servention 3 Removel from State 4 Donation 5 Other (Specify) GARRISON FOREST VETERANS 4-12-2000 OWINGS MILLS, MARYLAND of Funeral Segrice Licery 22. Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a Furth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, book, or heart failure. List only one cause on each line. Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) ACUTE PULMONARY EDEMA /Medical ONE DAY Examiner Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION physician end the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): USe 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END-STAGE RENAL FAILURE The lew requires that Records, à 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) the state 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Attanding 1 Natural 2 Accident 5 Pending investigation efter death.

Director: Aft
d in by the fur 1 Yes 2 No 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide 6 To the Hospital
within 24 hours
To the Funeral Completely filled Hospital 154 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. edical 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 4-7-2000 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MD 21204 FRANCIS KHOO, M. D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2000

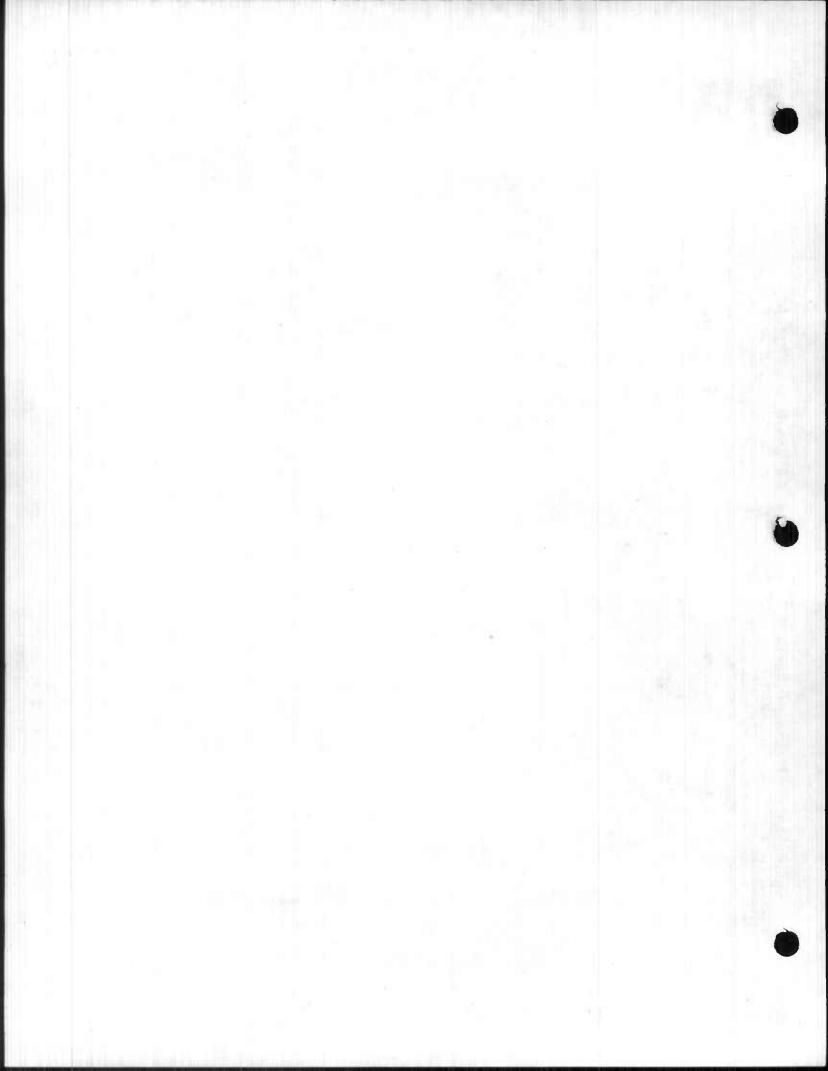


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2000 March 31, Physician Otis Η. 9:00 AM Craun /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Genesis Elder Care Severna Park Anne Arundel Months Days Hours Min. Sept. 19, 1910 Birthplece (State or Foreign Country)
 V1rg1n1a 6. Sex 1 2 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 89 199-07-5714 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 🎗 ☐ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 7842 Bodkin View Dr. 21122 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. pemilt. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Insportant: If then 27 is merited other than "natural", or then any injury or other treumsitic event, the Medical Francisco. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 th College (1-4or 5+) Ship Building Carpenter 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) 8 Steven Sr. Mamie Jane Redner Craun 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James McAteer (Personal 305 West Chesapeake Ave. Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 D Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Salem Lutheran Church Cem. 4/4/00 Dover, Pennsylvania 22. Name end Address of Fecility
Stallings Funeral Home PA 21. Signature of Funeral Service Lion 3111 Mountain Rd. Pasadena, Md. 21122 ar caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seach line. 23a. Part I. Enter the disease shock, or heart failure. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final Days disease or condition resulting in death) Electrolyte Imbalance Examiner Due to (or as a consequence of): Examine Parkinsons Disease The law requires that the death certificate be asscuted physician and s the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): for use as 987 signed by the a d be detached if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings available prior to completion of cause of death? been si 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: V Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a, Certifier 1[A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the causa(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-40521 April 3, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ochaney 3350 Wilkens Ave. Suite 302 Baltimore, MD 21229

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrer's Signature



Physician /Medical Examiner

pue

**Physician** 

/Medical

Examiner

10s. State

Directo

Funeral

Š

Be Completed

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with me M. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or ferms 23a or 23a-1; and Injury or other traumstic event, the Medical Examiner must be notified about.

With the Maryland

Examiner burial-transit physician a the burial Physician/Medical for use es signed by the e Completed by funeral director, 8 Certification: To To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely illied in by the fun

Attanding Physician: The lew requires that the death certificate be executed

this certificate

After

Box 68760,

Division of Vital Records, P.O.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Ware autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. edical 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year)

00055484

04-07-2000

DHMH 16 Rev 6/95

State Registrar

The Memorial Hospital 31. Data filed (Month, Day, Year)

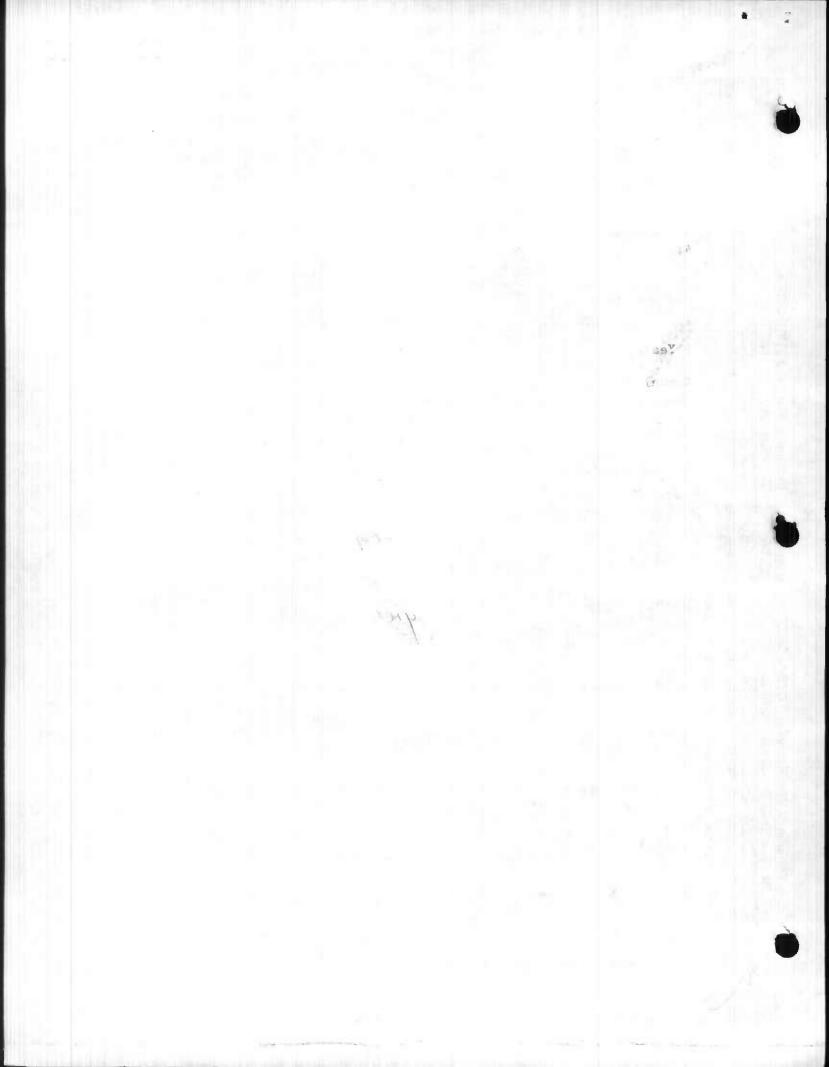


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harou Lacia



in. Ket



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #7 PER F.H. G782 4-10-00 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth **Physician** PHILLIP DONALD DAVIS 000 /Medical 4a Famility Name (If not Institution, giva street end-number) 4b. City, Town, or Lincation of Death 4c. County of Death Examiner mare n/a 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplece (Steta or Foreign Country) **Funeral** 100M 2□ F 212-18-3644 60-61 Director March 21 1939 Maryland Usual Residence of Dacedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits show Yas 2 No Director Md. n/a Baltimore 288-1 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 238 1731 S. Hanover Street 21230 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or item eny injury or other traumatic award. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0020 1 Yes 2 No Specify: Specify: white P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Disable n/a 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fethar's Name (First, Middle, Last) Be Philip Gwendolyn Davis Blottenberger 2 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 1006 Haman Way Roseville California 95678 Robert L. Davis (Brother) Baltlmore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Buriel 2√☐ Cremation 3 ☐ Removal from State Green Mount Cemetery \_5 ☐ Other (Specify) 4/07/2000 Baltimore, Md. 4 Donetion 21. Signatura of Funeral Service Licensee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. a 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onsat and Death Physician /Medical immediete Causa (Final disaesa or condition resulting in death) Examiner Dug to (or The law requires that the death certificate be executed Sequentially list conditions, If any, leeding to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Lest and Box 68760, the Due to (or as e conseque US9 88

Physician/Medical Examiner s been signed by t should be detack à Completed funeral director, Be Medical Certification: To after death Director: A completely filled in by

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24 hours a

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P.O.

Records,

Division of Vital Attending Physician: Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Ø Unknown 1 ☐ Yea 2 ☐ No

24a. Was an autopsy performed?

24b. Were autopsy findings availabla prior to completion of cause of daeth?

202 No 1 ☐ Yes 26. Place of Deeth (Check only one)

1 Yes 2 2 No

2000

25. Was casa referred to medical examiner? Hospitel: 1 Inpatient 1 Yas 2 No 27. Menner of Death

6 Could not be determined

28a. Date of Injury (Month, Dey Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

28a. Place of injury - At home, farm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Cartifian (Check only one)

1 Waturai

2 Accident

3 Suicide

4 Homicida

111 Certifying Physician: To tha best of my knowledge, daeth occurred at the time, date end place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, deta and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifia

29c. Licensa number

29d. Date signed (Month, Dey, Year) 16,

Location (Street and Number or Rural Routa Number, City or Town, State)

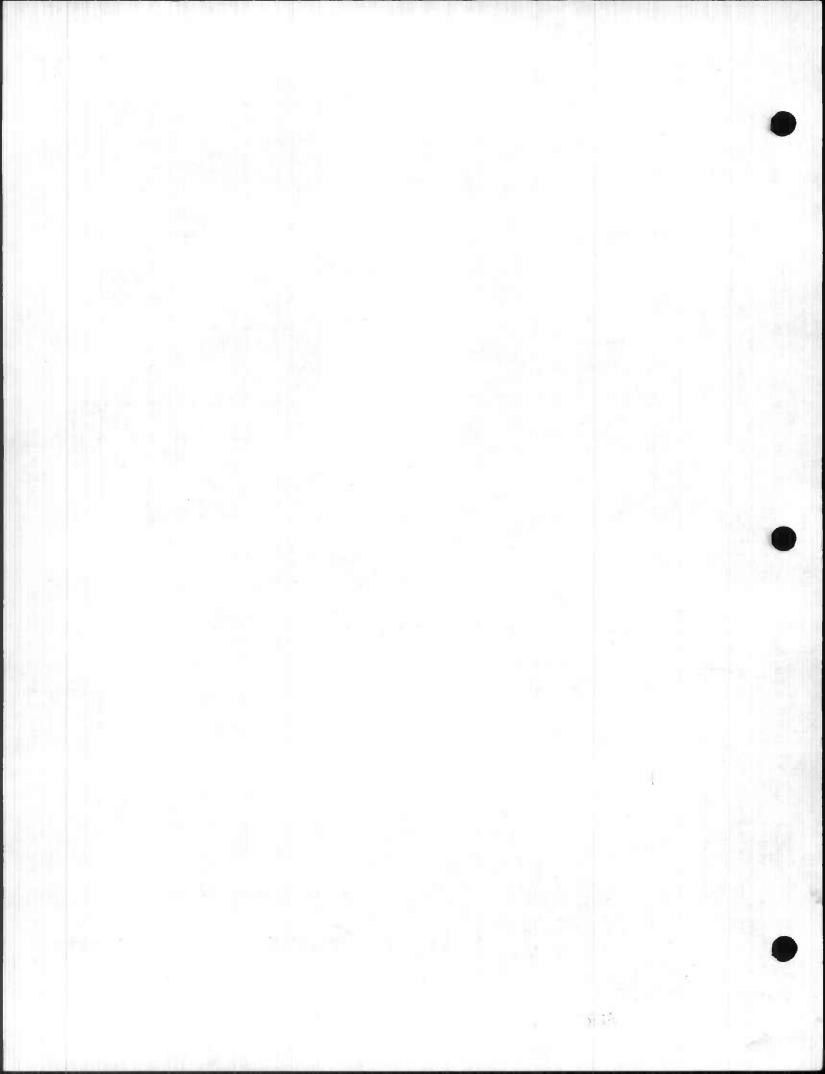
ie and add

700 31. Date filed (Month, Day, Year)

32 Redistrar's Signature

**DHMH 16 Rev 6/95** 

State Registrar



4/12/00 - Items 19a,19b -white out used to correct typo/dhb

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** April 4:50 pm Ronald 8,2000 Danielczyk /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square Hospital Center Franklin Baltimore nosedale If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 F Months 219-50-2938 54 Director May 17,1945 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits ehow Nerra 23a or 28a-f shortner must be notified at Md. Director Baltimore 1 Yes 2 No Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5403 Balistan Rd. 21237 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, Whita, etc. other treumstic avent, the Medical Examiner 1 Never Merried 2 Married Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) pas 1 and 2 should be filed with: of Health and Mental Hyglene. Hem 27 le marked other than 12 yrs. Laborer Universal Foods 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Edward Danielczyk Mildred Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Danielczyk wife 5403 Balistan Rd. Rosedale, Md. 21237 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Pages Important: If he any injury or o Apr 12 1 Burial 2 Cremation 3 Removel from State Christ Lutheran Cem. Department 4 Donation 5 Other (Specify) 2000 Dundalk, Md Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md 21222 Approximate Intervel Between Onset and Death or heart failure. List only that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical 2-10 yrs Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence Box 68760. Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by of Vital Records, P 8 page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No this cartificate f or Attending Physician: efter death. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division Aftar 1 Naturat 5 Pending investigation Injury i efter death.
I Director: Aft
d in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signeture end title of ce 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of p completed cause of death (Item 23a) (Type, Print) Samlai 6730 Holabir

DHMH 16 Rev 6/95

State Registrar 31. Date fited (Month, Day, Year)

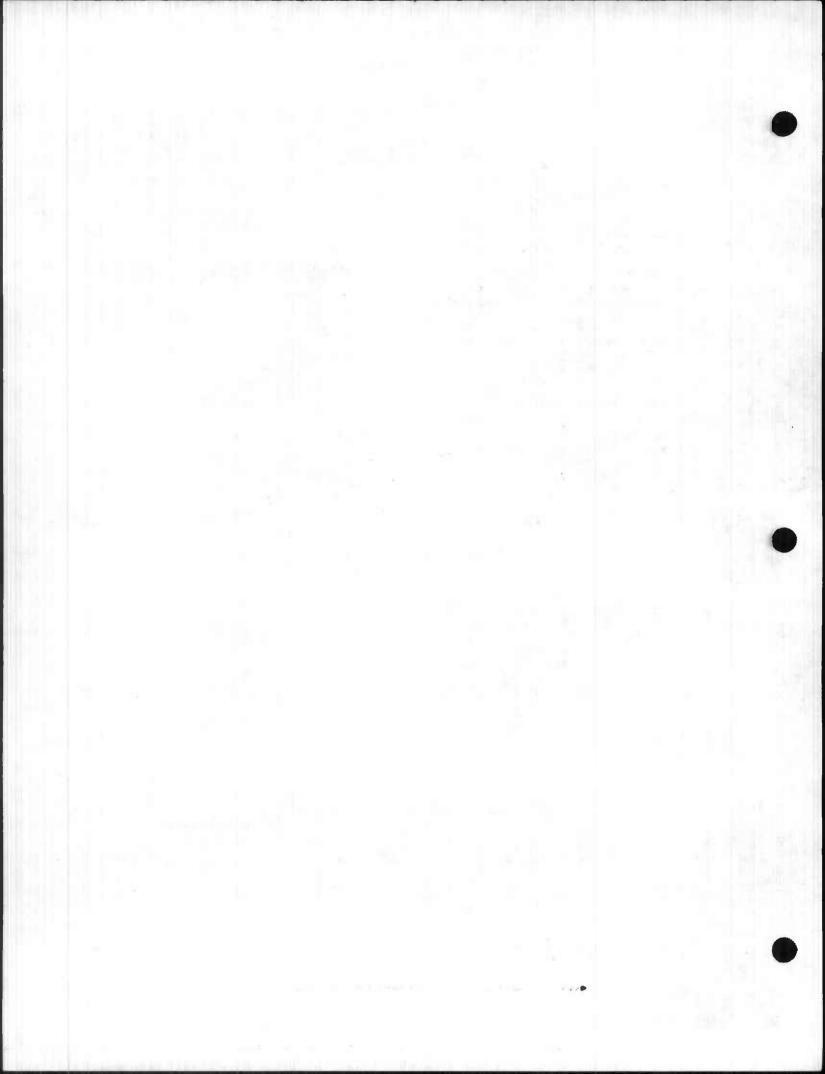
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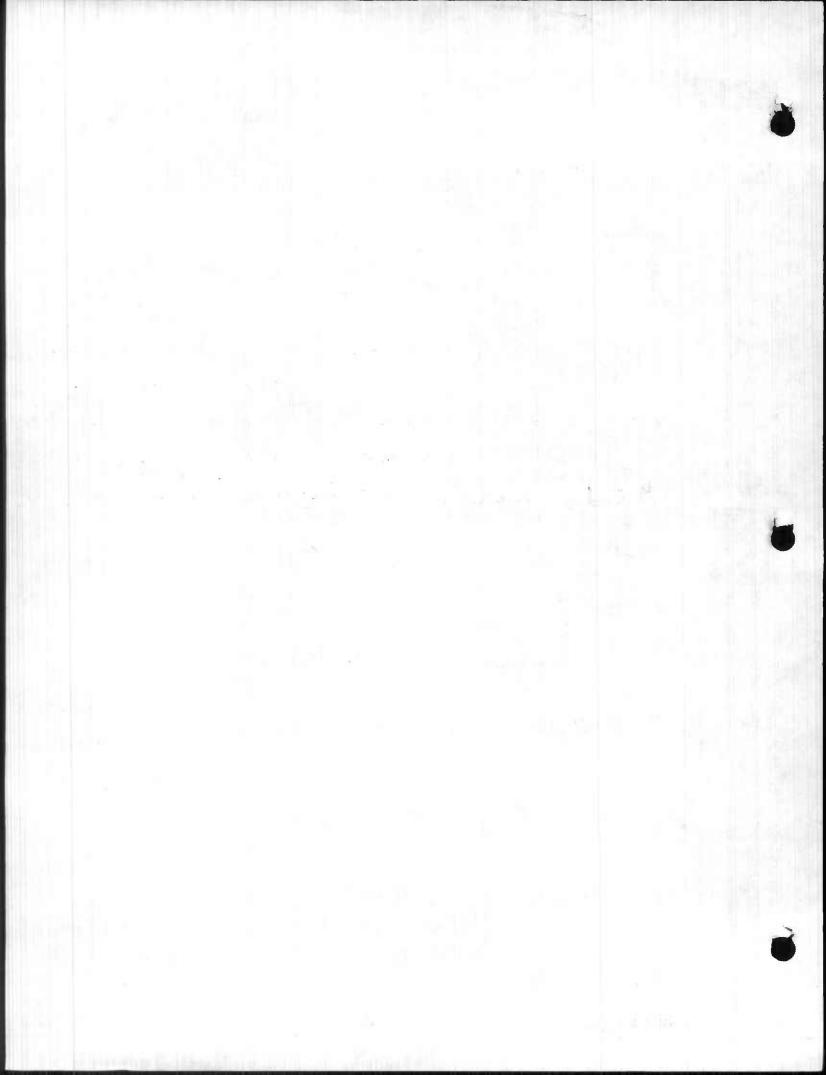
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32. Registrar's Signeture



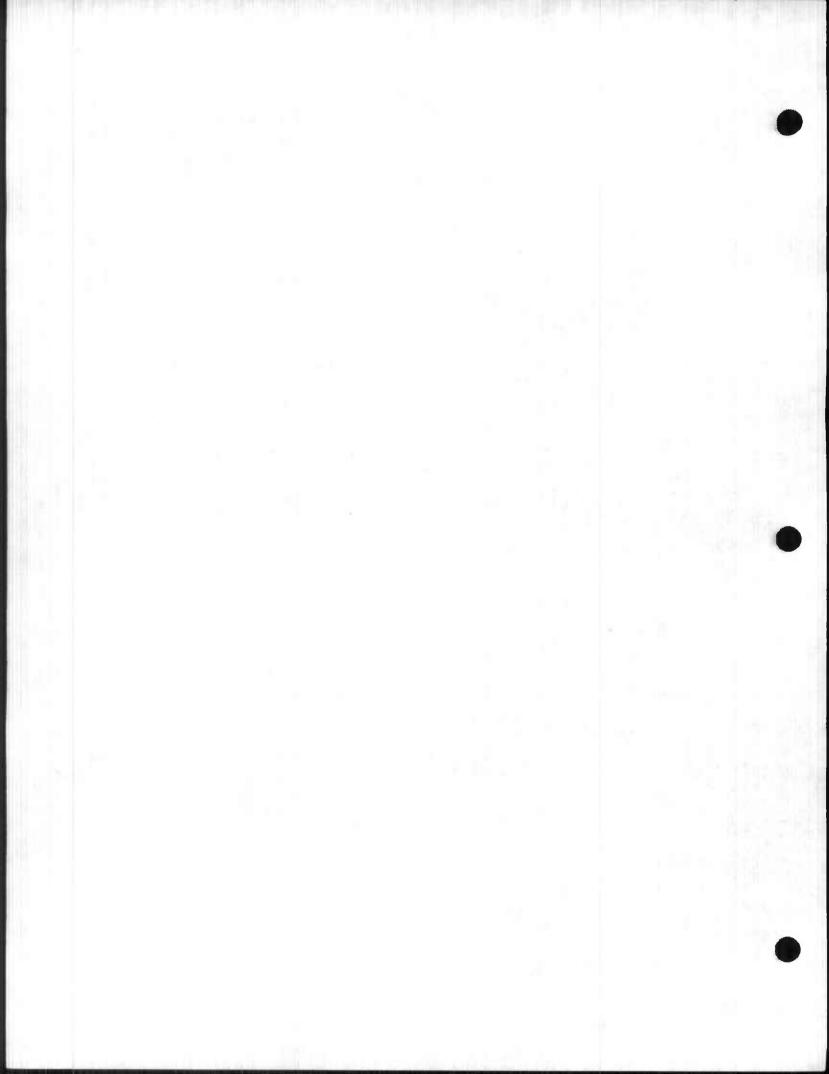
State of Maryland / Department of Health and Mental Hygien 0 11529

	Certificate of Death	Re	ng. No.	1329		
	1. Decedent's Nema (First, Middla, Last)	2. Data of Deat	h	3. Time of Deeth		
Physician	Evelyn J. Demmon	April	06, 2000	2:55pm		
/Medical Examiner	4a Facility Name (If not institution, give street end number)  4b. City, Town, or	-	4c. County of Death			
Examiner	Heritage Nursing Center Baltin	nore	NA			
Funeral	5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthdey) If Under 1 Yaer I H Under 24 Hrs.	8. Data of Birth (Month, Dey,	9. Birth	placa (Steta or Foreign intry)		
Director	217-18-9536 1 M 2 F 75 Yrs. Months Days Hours Min.	05-12-	-24	MD		
9 .	Usual Residence of Decedent					
arya data	10e. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
or 28a-f show be notified at Director	MD NA Baltimore			1 ☐ Yes 2 ☐ No X X		
Di pag	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	intry?		
ath w	10 N. Calvert Street Suite#722 21202		USA			
har death in them 23 siner must	11. Maritel Stetus  12. Was Decedent Ever In U.S. Armed Forcas?  13. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puert	pecify Yas or No- o Rican, atc.)	14. Raca - Amer Bleck, White			
DZO	1 Never Merried 2 Merried 1 Yas 2 No If Yes, Give 1 Yes 2 No Specify: Yeer or Datas:		Specify: Wh	ite		
1 21215-0020 ed within 72 hours at ygient "rathural", or nt the Medical Exam Completed by F		tina	16b. Kind of Business/Industry			
Med in	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)  Elementery/Secondery (0-12) College (1-4or 5+)	Killy				
8 E 8 J ()	Unknown NA Laborer		various	trades		
De system Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle, A				
yla Ment Ment Ment Ment Ment Ment Ment Ment			Kutchern			
Maryland d 2 should be file the and Mental Hy T is marked oth traumatic event To Be (	19e. Informent's Neme/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Ru					
- 5945	Robin M. Goldman, Esquire 10 N. Calvert Stre					
Saltimore emil. Pages 11 Appartment of He Important: If Item ny Injury or other dose.	20a. Method of Disposition  1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removel from Stete	Date	20c. Location - City or T	own, Stete		
Pag Pag My o	4 □ Donetion 5 □ Other (Specify) Greenmount Cemetery C	04-11-20	000 Balti	more, MD		
mil.	21. Signeture of Funerel Service Licensee 22. Nema end Address of Fecility	altimor	e, Maryl	and 21202		
00 88228	A lades Warred WM.C. March FH ]					
A	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart fellure. List only one cause on each line.	or respiretory arre	est,	Approximate Intervel Between		
Physician	Show, or hour foliate. Slot only one cause of each line.		1	Onset and Death		
/Medical	Immediate Ceuse (Finel disease or condition resulting in cheetty)  a. SEVERE MALNUTRITION		1			
Examiner	resulting in deeth)  Due to (or as e consequence of):					
	BNEMIA					
), executed in and ial-transit Examiner			T			
O, 00, 10, 10, 10, 10, 10, 10, 10, 10, 10	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initileted events	DACIC				
68760, fileste be executed g physician and as the burial-transit	that initiated events resulting in death) Lest  Due to (or es a consequence of):		1	1		
= 0 0	BILATERAL PLEURAL EX	EUSIDI	2			
Box auth cert for usa	O.D. EP) TORVICE   COUNTY	- 4.5.6.				
IS, P.O. Box (as that the death certified by the attending be detached for usa a by Physician/M.	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dld to	bacco use contribute	to the cause of death?		
P.O. wat the d by the detache	DEMENTIA	1 □ Y	88 2 No 3 Pr	obably 40 Unknown		
S, as the as the bed bed by	1200/614//4					
Records, he law requires the has been signe age 2 should be or		24a. Wes a perform	ned?	Vare autopsy findings veileble prior to		
Die 2 st				completion of causa of deeth?		
Vital Record sician: The law requir contlicate has been s lirector, page 2 should o Be Completed		1 🗆 Ye	s 212No 1	☐Yes 20 No		
/ital	25. Wes case referred to medical 26. Place of Dec	eth (Check only on	e)			
Of Vita Physician: this certific ral director,	examiner? Hospitel: Other:		ence 6 Other (Spec	eify)		
Division of Vital after deathing Physician: The or attending Physician: The ordificate of the funeral director, put in by the funeral director, put entification: To Be Co	27. Manney of Death 28a. Date of thiury 28b. Time of 28c. Injury et	28d. Describe ho	ow injury occurred			
Vision Attending or death. ector: After by the funa	2 Accident Investigation M 1 Yes 2 No					
VIS Atte	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	281. Location (St City or Town	reet end Number or Ru	ral Route Number,		
Division of the or attending Prints after death.  In Director: After the in by the funers Certification:	building, etc. (Specify)	Only of Your	. 0.010)			
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completally filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred.	, and due to the ca	ause(s) and manner as ate end piece, and due	stated. to the cause(s)		
the thin 2 the mple	and menner steled.					
L N L S	29b. Signeture and title of certifiar  29c. License number	2	9d. Data signed (Month	, Day, rear)		
	Sander K Julia 14.0. 02/188		4/1/00			
V	30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)	Λ4.	2/2-			
	Sandy Mille Z Market- Place Dunda	ox MD	21222			
State	31. Dete filed (Month, Day, Year)  32. Registrer's Signeture					
Registrar	APRIO 2000 Server & South					



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1 1 5 3 0

					Cei	rtifica	ate of	Death			Reg. No.			
10.0	1. Decedent's Nama (First, Mid-	dia, Last,	)							2. Data of Dea		Yaar	3. Time	a of Death
Physician /Medical	MARKARET	mA	RY E1	JANS						APRIL	Day 05	2000	6.2	20 pm
Examiner	4a Facility Nama (If not instituti		-					4b. City, To	own, or Lo	ocation of Death		ty of Death		7
	HARBOR H	OSPI	TAL CE	NTPE	2			BAL	Win	TORE	n/	a		
Funeral	5. Social Security Number	6. Se	x 7. A	ga (In yrs.	last birthday)	if Und	dar 1 Yaar	If Undar		8. Data of Birt (Month, Da	th V Veer!	9. Birthp	laca (Sta	ta or Foraign
Director	220-22-7872	1	DM 2XDF	74	Yrs.	MONIT	Days	Hours	PAHIT.	Oct. 21		Mary		
D.	Usual Rasidance of Decedant													
ahow thom	10a. Stata 10b. Count				ty, Town or Lo							10		City Limits
cto cto	Md.	n/a	a	Ba	ltimor	e							X X	as 2 No
Demnit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglens. Department of Health and Mental Hyglens. Deferred or Health and 27 is marked other than "returnet", or itema 23e or 28e-f show any Injury or other treumatic event, the Health and Emmisser must be not that at other.  To Be Completed by Funeral Director	10e. Street and Number 117 E. Barney	y St	reet			10f. 2	Zip Coda	2123	0		10g. Citizan o	What CounUSA	try?	
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ar, or he by Fu	1 Nevar Married 2 Ma 3 Widowed 4 Divorce		1 ☐ Yas 2√ If Yas, Give Yaar or Datas	] No			2 <b>1</b> No			, , , , , , , , , , , , , , , , , , , ,	Spec	- sh	ite	
2 ho	15. Deceda	nt's Edu	cation		16a. Dece	dant's U	sual Occu	pation	t of work	ina	16b. Kind of	Businass/Inc	lustry	
within 7	(Specify only high Elementary/Secondary (0-12)		Collega (1-4o	5+)	lifa.	DO NOT	usa retire	during mos	st of work	ung				
of the Co	12		0	0.,	Hous	ewif	e				Home	Owner		
tal Hygid d other event, to	17. Fathar's Nama (First, Middle	, Last)						18. Moth	ar's Nam	a (First, Middle,	Maiden Sum	ıma)		
should be to and Mental Portante every urmatic every To Be	William O'Ne	eill						Ma	ry E	. Gardne	er			
end No.	19a. informant's Name/Ralation	ship (Ty	rpe, Print)		19b. Mailir	ng Addra	ass (Straa	t and Numb	er or Rur	al Routa Numbe	er, City or Ton	n, Stata, Zip	Coda)	
end 2 patth e n 27 ie	Kathleen Cole		(Daughte	r)	414	Sar	nders	Stre	et B	altimor	e, Md.	21230		
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tant	4 Donation 5 Other		-	Ce					1				TV,	ria.
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/Medical	Immediata Causa (Final		MVIC				500	TI	. 1			1	11 6	IOUR
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physicians the burner of the b	rasulting in death) Last			Dua to (c	or as a conseq	uance o	н):							
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d by the attandid	Part II. Other significant condit	ions cor	ntributing to death	but not ras	sulting in the u	ndarlyin	g causa gi	van in Part	f.		tobacco uss			
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cate has been signed by the attandit page 2 should be detached for use Completed by Physician/										24a Was	an autopsy	24b W	ara suton	sy findings
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200												of	death?	,
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terthinerel	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	ina	28a. Data of In (Month, E	jury lay Year)	28b. Tima o injury	4	28c. Inju	ny at ork?		28d. Dascribe	how injury occ	urred		
ath.	2 Accident invas	tigation				M		Yas 2	No No					
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unter neoptical or Arendang Within 24 hours after death. To the Funerei Director: After completaly filled in by the funer Medical Certification:	29a. Certifier  29a. Certifier  (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and placa, and due to the cause(s) and manner as state   2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and placa, and due to the cause(s) and manner as state										se(s)			
Med mple											29d. Date sig	ned /Month	Day You	ar)
* 6 0	and the disconnection of the d													
	K.B. Sans		MD				RE	S 00	00		more,	700		
$\sim$	30. Nama and addrass of perso	n who co	ompleted causa of	death (Itar	m 23a) (Type,					BALTI	MORE,	MD-	-212	225
	KAVITA SANI	THU	HAR	BOR	HOSPIT	AL	CENT	TER.	300	1 500	TH HA	NOVE	RS	TREE
State	31. Data filed (Month, Day, Yea	r)	32. Regis	trar's Sign	atura	4	200	uks						
Registrar	100	1 0	annh .	Charles		-	18							



**Physician** /Medical Examiner requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifica

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be nothed at

Director

Funeral

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**burial-transit** 

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31. Date filed (Month, Day, Year)

APR 1 0 2000

Baltimore, Maryland 21215-0020

Registrar DHMH 16 Rev 6/95

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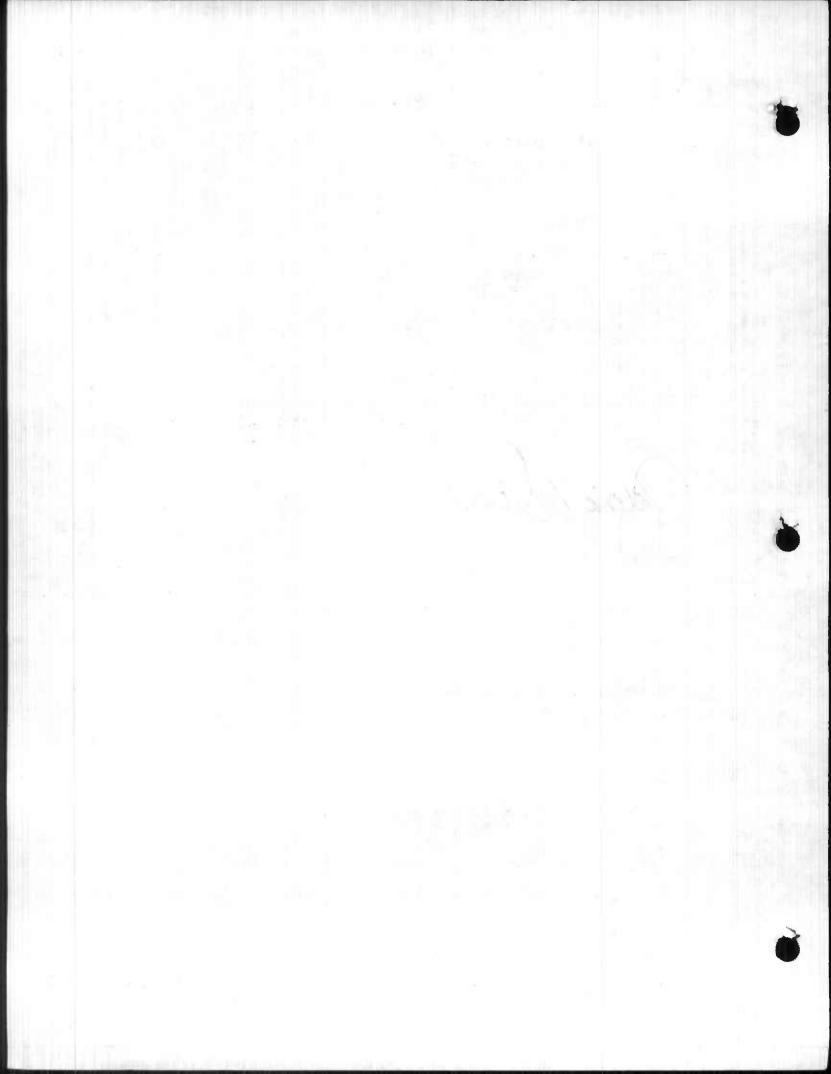
EASTERN

32. Registrar's Signature

AVENUE, BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2*0*00



State of Maryland / Department of Health and Mental Hygiene (1)

sician edical		EMORY	JAMES	GI	LMORE							2. Date of De Month APRIL	05	2000		ma of Death
miner	46	e Facility Name (I				15.			4			cation of Deat		ty of Deeth		
	5	FRANKLI  Social Security N		6. Sex	HOSPI		. last birthday	if Under	1 Year	ESSEX		8. Dete of Bir	reh	IMORE		tata as Causias
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ral Director		0e. Street and Nur 1418 E. J		d.			N.	10f. Zip	Code	21234			10g. Citizen of US		ntry?	
by Fune		1. Meritel Status  1)(Never Merri 3  Widowed		ied	Wes Deced Armed Ford 1 Tes 2 If Yes, Give Yeer or De		J,S. 13.	<ul> <li>S. 13. Wes Decedent of Hispenic Origin? (Specify Yes or if Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes XXNo Specify:</li> </ul>					r No- 14. Rece - American Indian Black, White, atc.  Specify: White			en,
Completed	-	(Spec		st grade co.	Education grade completed) College (1-4or 5+)			edent's Usua e kind of wo DO NOT us	el Occup rk done se retired	ation duning most t)	of work	ing	16b. Kind of			
Con		10 yrs N/A 17. Father's Name (First, Middle, Lest)					Mai	ntena	nce				McDona		Corp	).
To Be	7. Father's Neme ( James Ma			re								, Meiden Sume Turnbu	,			
		9a. Informant's Ne Diana G			Print)								Store,			
	20	Diana G. Simmons  8282 Mill Pond Drive James Store, Va. 23128  Oa. Melhod of Disposition  1												ote		
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lan/Medical Examiner	li de no	4 Donetion  1. Signature of Fu  2. Part Laner II shock or heat mmediate Cause ( disease or condition esulting in deeth)  Sequentielly list containly, leading to in euse. Enter Unde ausa (Disease or list initiated events	5 Other (S) ne disease, or reliable. List  Finet n  Inditions, impediate rhying injury  Last	complicationly one c.	Pyor Myor Coru	used the deech lina.  Due to (	or es e conse	ns Cerronal	nBland Addressahn Belde of dyir	einhe ss of Fecility Funer Lair F. g., such es	ral H	Home Baltimo prespiretory e	re, Mar	ryland	Approfiterve Onset	236 ximete al Between and Deeth
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State Registrar

31. Dete filed (Month, Day, Year) APR 1 0 2000

30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)

HAMA MAN D. KOREW 1

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

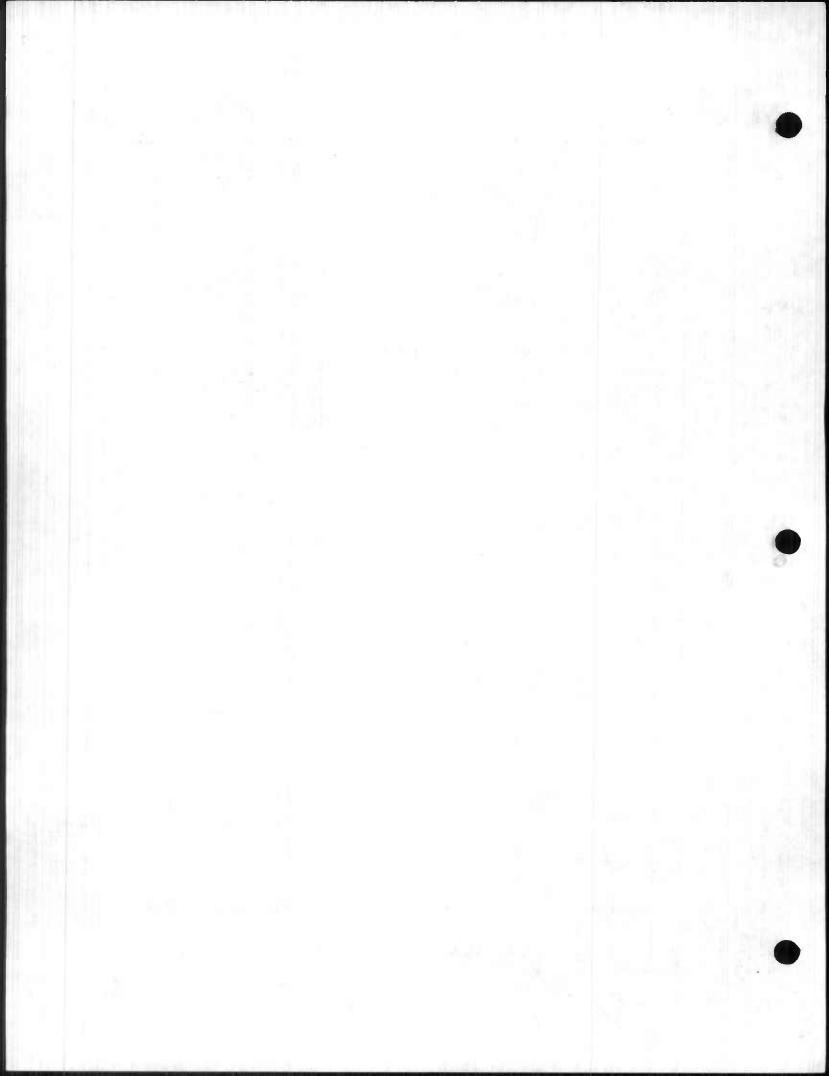
APRIL 05,2000

State of Maryland / Department of Health and Mental Hygiene 00 11533

						Ce	ertificate of	Death			Reg. No.	0	11000
Dharinin		Decedent's Nam	a (First, Middla, Li	est)						2. Data of Dec	th Day	Year	3. Time of Death
Physician /Medical	ŀ	Harold	Samuel H	agy						April	8, 2000	)	7:30 am
Examiner	48	Facility Nema (I	f not institution, gi	ve street and num	ber)			4b. City, To	own, or Lo	cation of Death			
			Side Pr					Hamst			Carro		
uneral rector	2	Social Security N	92	Sex XXM 2□F	79 / Age (In yrs.	last birthday Yrs.	Months Day:		Min.	8. Dete of Birt (Month, Day Sept. 2	, Year) 29, 1920	9. Birthp Coun	laca (Stata or Foraign ltry)
	_	sual Rasidance of Da. Stale	10b, County		10c. Ci	ty, Town or I	ocation					1	0d. Inside City Limits
ring round by round at		MD	D-1+0			kesvi							1 ☐ Yes 2 ☑ No
50	10	MD Da. Street and Nur	Balto			KESVI	10f. Zip Coda				10g. Citizan of V	What Cour	
Funeral Director		16 Estat					21208				USA		
وَ		I. Marital Status  1 Nevar Merri  3 Widowed	ied 2 Married 4 Divorced	12. Was Deced Armed Ford 1 Yas 2 If Yes, Giva Year or Dat	eas?	),S. 13	. Was Decedant of If Yes, specify Cu 1 Yas 2 XNo			ecify Yes or No- Ricen, atc.)	Specify	e - Amaric ck, While, ': Whi	elc.
Completed by		(Spec	15. Decedent's E	ducetion ade completed)		16a. Dec	edant's Usual Occi	upation a during mos	st of work	ino	16b. Kind of B	usinass/Ind	Justry
	. –	Elementary/Seco		Collega (1-	4or 5+)		e kind of work don DO NOT usa retir	ed)			D - 4 1 7 - 1		+1
S				+2		Mach	inist	T			Bethle		teei
Be	1		(First, Middla, Las	1)							Maidan Suman	na)	
2	h	Iilliam F	łagy					EIS	1e M	. Snitc	ner		
200		9a. Informant's Na	ame/Retetlonship	(Type, Print)			iting Addrass (Street						
	H	larold Da	ivid Hagy	sor			East Ches	tnut	Lane	Reiste	rstown i	MD 21	136
	20		oosition Cremation 3 [ 5 Other (Speci		tate	cematary, cr	position (Name of ama <i>tory</i> or other pi Cremation		4.	Dete / 10 / 00	20c. Location - Hamstead		wn, Steta
any injury once.	2	1. Signature of Fu	neral Service Lice	nee	7		22. Nama and Add	ress of Fecili	ity	11824 R	eisters	town	Road 136
	4	3a Fartt Enter t	he disease or con	enlications that co	Lead the deal	1	ntar tha moda of d					10 -1	Approximeta
for use as the burial-transit clan/Medical Examiner	d n	nmediate Cause is isaase or condition isulting in death) equentially list co any, leeding to in ause. Entar Unda ause (Disease or ause (Disease or ause) (Dis	nditions, nmadiata rdying Injury	a. Pul c. Cor	Dua to (	or es e cons / (y or as a cons / (MO / or es e conse	FIBRO equance of): Na I-L	5/3					
be detached for use by Physician/I	L									1		1	
leted by Physic	P	art II. Other signif	icant conditions	contributing to dea	ith but not ras	sulting in tha	undarlying ceusa (	givan in Part	I.				o the cause of death
4										1	Yes 2□ No	3 □ Pro	bably 4⊠ Unknow
Completed by										24a. Was	an autopsy mad?	ev	ara eutopsy findings ailable prior to impletion of ceuse death?
age 2										10	res 2 No		□Yas 2M No
. 0		5. Was cesa refar	red to medical					26 Plac	a of Deat	h (Check only o			
To Be Com		examinar?		Hospital:	patient 2	ER/Outpati	ent 3 DOA	Wher:		ma 5 ☐ Rasi	1	nar (Specia	M Assisted
		7. Manner of Deat 1 Natural 2 Accident		28a. Dete of (Month	•	28b. Time Injury	of 28c. In				now injury occur		" Living
Certification:	3 Suicide 4 Homicide  6 Could not be datermined  28a. Place of fnjury - At homa, farm, street, factory, office building, atc. (Specify)									28f. Location (Streat and Number or Rural Routa Number, City or Town, State)			
edical C		9a. Cartifiar (Check only one)	1 Certifying P	hysician: To the base	als of axamina	owledga, das ation end/or	ath occurred at tha investigation, in my	tima, data ar opinion, dar	nd ptace, ath occur	and dua to tha red et the tima,	ceusa(s) and m date and place,	ennar es s and dua te	teted. o tha cause(s)
completely filled in by the		9b. Signeture end	fitla of certifiar		1		29c. Lice	nse number			29d. Data signe	d (Month,	Day, Year)
O			May	000 n	LUC	)	T	4-20	1/-		11/10	Inn	
)	30	). Nama and addr	ess of parson who	completed ceusa	of death (Iter	m 23a) (Type		hain	do 1	, MI	) 3//	52	
	2	Data filed (14-	th Day Varri	alt) MU	giguars Signi	100	WES	min	TO	1000		7	
State Registrar	3	I. Date filed (Mon	ADD 1 n	32. He	grafar's Signi	atura	A San	a de					
9.000			MERTI	710.01	And the same	/	W KARA S	The Part of the Party					

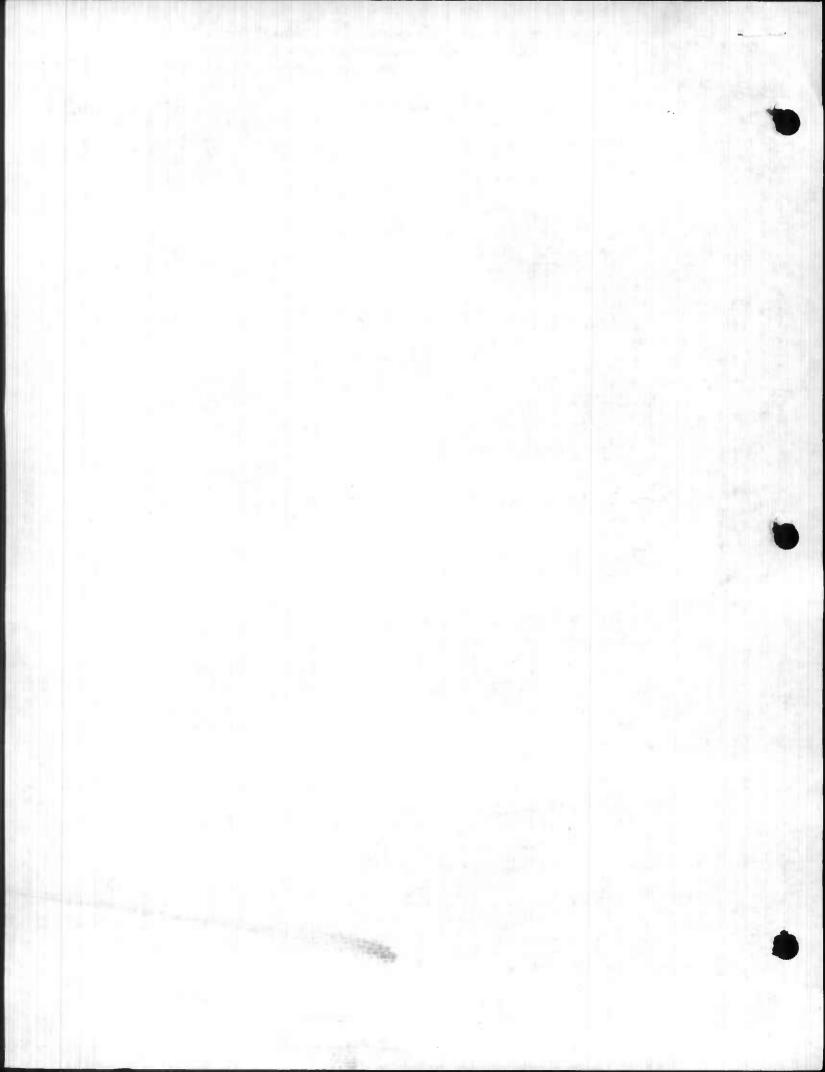
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		State of Marylar		cate of Dea	ath	Reg. No.	00 11534
Physician	Decedent's Name (First, Middle, in the control of the control		0		2. Date		Year 3. Time of Death
/Medical	Catherine	Bea Hof	tman		Trac		2000 1455
Examiner	4a Facility Name (If not institution,	1	. 1		y, Town, or Location of		ty of Death
	9			A STATE OF THE PARTY OF THE PAR	ndar 24 Hrs. 8 Date		shington
eral ctor	235-04-0928	7. Age (In yrs. 84			urs Min. (Mont	of Birth th, Day, Year) 28,1915	Birthplace (State or Foreign WV.
rector	Usual Residence of Decedant  10a. State 10b. County	10c. Ci	ty, Town or Location	1		20,2723	10d. Inside City Limits
6	Md. Washin						1,□ Yes 2□ No
ect	10e. Street and Number	gcott	gerstown	I. Zip Coda		10g Citizen o	f What Country?
Funeral Director	566 Salem Ave.			21740		USA	
une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was I	ecedent of Hispani specify Cuban, Me	ic Origin? (Specify Yes exican, Puerto Rican, etc	or No- 14. Ra	ace - American Indian, ack, White, etc.
by F	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva A	10Y	es 2 No Spe	ecify:	Spec	ily:
5		Year or Dates:	10- 01	1111		10h Kindari	White
Completed	15. Decedent's (Specify only highest of	erade completed)	(Give kind o	Usual Occupation of work done during OT use retired)	most of working	160. King of	Businass/Industry
Ĕ	Elamentary/Secondary (0-12)	College (1-4or 5+)	Homemake			Home	
	17. Fathar's Name (First, Middle, La	st)	Tromonare		Mother's Name (First, M		ime)
0 20	Frank Brown Be	ell		Sa	rah Louise	Littlet	on
9	19a, Informant's Name/Relationship	(Type, Print)	19b. Malling Ad		lumber or Rural Route N		
	Barry R. Hoffman						
	20a. Method of Disposition	20b. I	Place of Disposition	(Name or	. Hagerstow	20c. Location	140 1 - City or Town, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Li Hemovai from State	cemetary, cremator, cerstown (		2/22/0	00 Hagerst	orm Md
	21. Signature of Funeral Service Lice				Z/ZZ/C	nagerst	.OWII, M.
	W + + 0	2			encer Funer		
	22a Part Enter the disease or or	moliantions that accord the days			y, WV. 25425		Approximate
	23a. Part1. Enter the diseasa, or co shock, or haart failure. List on	ly one cause on aach lina.	ui. Do not enter the	mode of dying, suc	or as cardiac or respirat	ory arrest,	Approximate Interval Between Onset and Death
	Immediata Cause (Final	7 1. 1	L				
	disease or condition resulting in death)	· Dehydra					Days
e		Swallowi	or as a consequence				Days
Ē		D	4	function			10073
Examiner	if any, laading to immediate	Mental	Status				h
edical	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events	C	or as a consequence	change			Days
	resulting in death) Last	Dement		. 01).			Months
3		d. Demani					1047047
icie	Part II. Other significant conditions	contributing to death but not res	sulting in the underly	ing cause given in l	Part I 23b	. Did tobacco use o	contributa to the cause of death
Completed by Physician/M	Electrolyte imbola					1 ☐ Yes 2 ☐ No	
y F	Electionale una	1163		Instritio			
5	chanic betration	- polmonary Lisea	ماه ما	stipation	24a.	Was an autopsy performed?	24b. Were autopsy findings available prior to
pier	Owner SALINOS	1		> / ( N		parioniliou	complation of ceuse of death?
HO	osteoperasis		N. 1.4	rotic Jer	remidence !	1 Yes 2 No	1 □ Yes 2 ₽ No
9	25. Was case referred to medical		17"	- 1	Place of Death (Check		
To Be	examiner? 1 ☐ Yas 2 € No	Hospital:	ER/Outpatient 3[	Othor	□ Nursing Home 5 □		Mhar (Specify)
n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?		cribe how injury occ	
atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigat		Injury 2:55 PM	- 1 Yes	2 🗆 No		
	3 Suicide 6 Could not datarmine	be d 28a. Place of Injury - At h building, etc. (Special			28f. Loca	tion (Street and Nur or Town, State)	nber or Rural Routa Number,
	4 El Homode	building, etc. (Specia	19)		Ony (	or rown, State)	
edical Certification:	29a. Cartifier 1 Certifying I (Check only one)	Physician: To the best of my known arminer: On the basis of examina and manner stated.	owledge, death occuration and/or investig	rred at tha tima, da ation, in my opinion	ita and place, and due to, death occurred at the	o tha causa(s) and r time, data and place	mannar as stated. e, and due to the cause(s)
¥	29b. Signature and title of partition			29c. License num	nber	29d. Date sign	ned (Month, Day, Year)
	1111	da		D4608	7 1		
	30 Name and St. William	_ mp	020) (7	טייט	) 1	MINLON	21,2000
	30. Nama and address of person wh		n 23a) (Type, Print) 1 Street	14,600.	town mo :	21740	
	31. Data filed (Month, Day, Year)			(700701)	THE POLL	~1710	
tate trar	MAR 2 2	2000 32. Registrar's Signa	4	brand	,		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Year **Physician** JAMES HUNDLEY 2000 6 4b. City. Town, or Location of Death /Medical 4e Facility Nama (If not Institution, giva street and number) 4c. County of Death **Examiner** SAMARITAN Baltimore
If Under 24 Hrs. 8. D
Hours | Min. (A G000 HOSPITAL If Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 22652 870 XXM 2DF 60 Yrs. Director VA Usuel Rasidance of Decedant the Manyland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Bhow Examiner must be notified at MD NA Baltimore Director M☐ Yes 2 ☐ No 280-1 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? 8 1935 Ramblewood Road нета 23а 21239 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or their any Injury or other traumatic event, the Medical Exemp 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Bus Company 10th Grade Self-employed NA 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be 2 George Hundley Muse Lucille 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Neme/Ralationship (Type, Print) 1935 Ramblewood Road Baltimore, Maryland Jean Hundley 20e. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Union Hope Bapt. Ch. Cem. 04-12-2000 Ino, VA. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 ladus WM.C.March FH 1101 E. North Avenue Warren 23e. Part 1. Entar the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disaasa or condition rasulting in daath) /Medical MYOCAR DIAL INFARCTION Houns Examiner Due to (or as a consequence of): Physician/Medical Examiner YEARS -ARDIOMYOPATHY The law requires that the death certificate be executed physicien end s the burial-transit Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or injury Dua to (or as a consequence of): 68760 HYPERTENSIENDUA TO (or as a consequence of): YEARS that initiated events resulting in death) Last Box ( P.0. Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown s cartificata has been signed director, page 2 should be de Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 2 2 No cartificata 1 Yes 1 Yes 2 No of Vital Hospital or Attending Physicien: 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 00 Medical Certification: To 1 Depatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After t Division 1 Natural 5 Pending investigation deeth. 1 Yas 2 No 2 Accident within 24 hours after deet To the Funeral Director: 3 Suicide 6 Could not be delamined 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 4 Homicida Descripting Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. 29a. Cartifiar completely ( (Check only one) \$ 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 28 ELIZABETH NGUYEN 19625 BOULDAND MD. 2000 6

DHMH 16 Rev 6/95

State Registrar MUSPITAZ

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

GOOD SAMARITAN

32. Registrar's Signatura

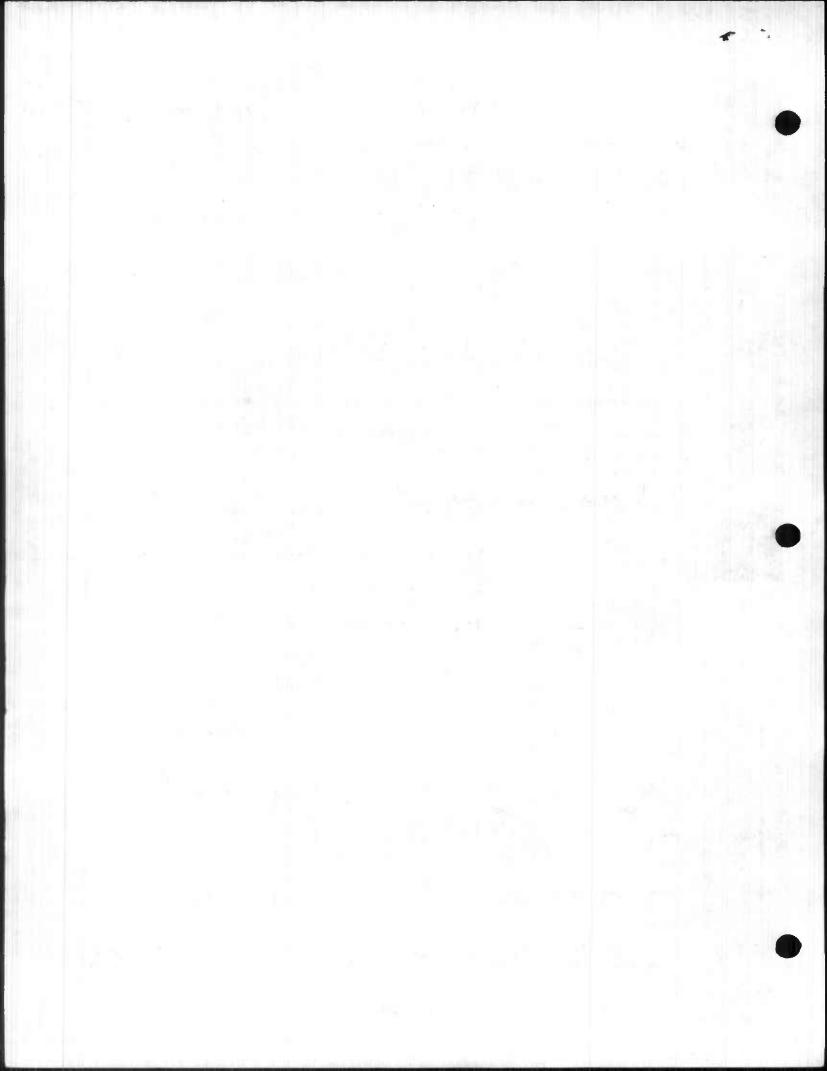
BUZABETH NGUYEN

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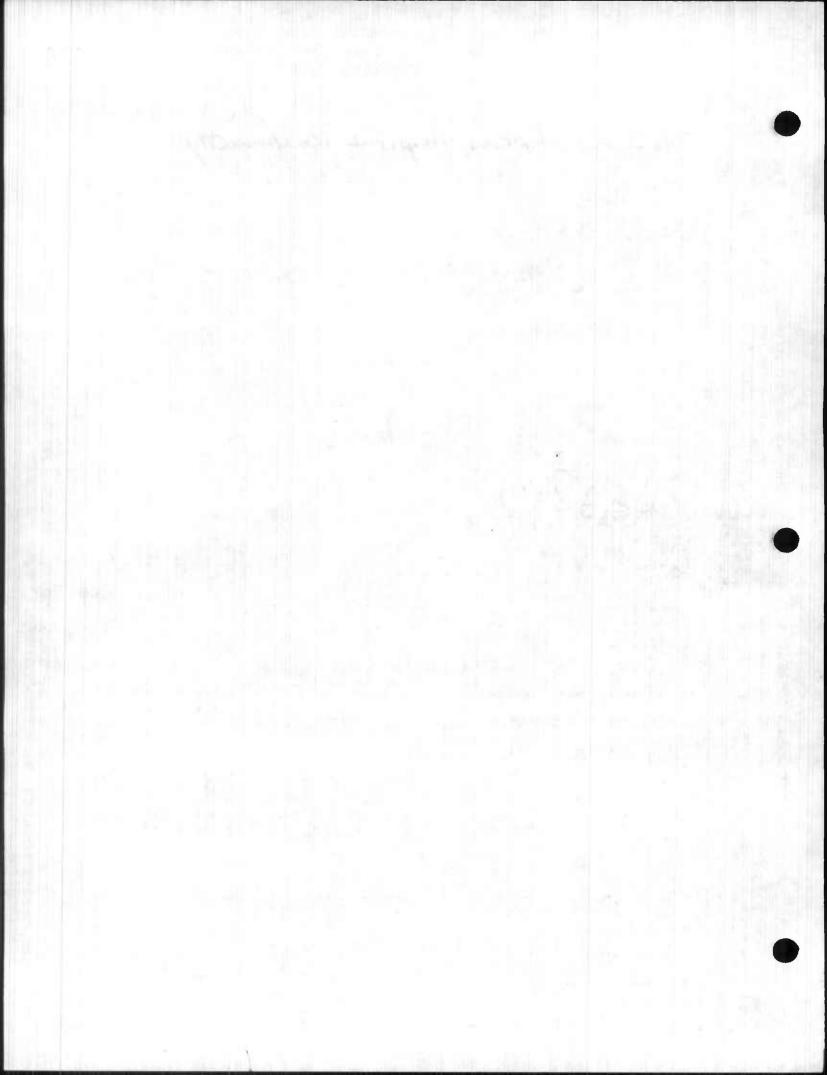
21239



State of Maryland / Department of Health and Mental Hygiene 00 11536

	Certificate of Death		Reg. No.	11330	
.1	1. Decedent'a Neme (First, Middle, Last)	2. Dete of De Month	path Dev	3. Time of Death	
ian ical	Willis	April	6.2	000 08:23	
iner	4e Facility Name (If not institution, give street end number)  4b. Gity, Town,	or Location of Deet	h 4c. County	of Death	
	THE Johns Hopkins Hospital Baly	timore Cit	4	N/A	
	5. Social Security Number 6. Sex 7. Age (In yrs. last binthdey) If Under 1 Yeer If Under 24 Months Deys Hours N	Hrs. 8. Dete of Bir Min. (Month, D)	V. Year)	Birthplace (Steta or Foreign Country)	
	216-68-9886	June 6		Maryland	
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
tor	Maryland Anne Arundel Pasadena			1 ☐ Yes 2 No	
Directo	10a. Street and Number 10f. Zip Code		10g. Citizen of W	/hat Country?	
0	592 Riverside Dr. 21122	1 1 7	U:	SA	
Dec	11. Merital Stetus  12. Was Decedent Ever in U.S. Armed Forces?  13. Wes Decedent of Hispenic Origin If Yes, specify Cuben, Mexican, P.	? (Specify Yes or No			
2	1 Never Merried 2 Merried 1 Yes, 2 No If Yes, Give 1 Yes, 2 No Specify:	dello ricali, etc.)			
9	3 Widowed 4 Divorced Yeer or Detes:		Specify:	White	
DIE	15. Decedent's Education (Specify only highest grade completed)  16e. Decedent's Usual Occupation (Give kind of work done during most of life. Do NOT use ratired)	workina	16b. Kind of Bu	siness/Industry	
e Complet	Elementary/Secondary (0-12)   College (1-4or 5+)		7112		
	9 th Truck Driver		Dump Ti		
Be		Neme (First, Middle			
9		jorie	Haa		
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Street and Number of				
	Gail NacComas (Sister) 592 Riverside Dr. Pa	Dete Dete		City or Town, Stete	
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete	1			
	4 Donetion 5 Other (Specify) Metro Crematory Inc.	4/10/00	Baltimor	re, Maryland	
	21. Signature of Funeral Service Licensee Stallings Funeral	1 Home PA			
	3111 Mountain Rd.	. Pasadena	a, Md. 2	1122	
	23a. Pert! Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, auch es car shock, or heart failure. List only one cause on each line.	rdiac or respiratory e	errest,	Approximate fintarvel Between	
6				Onsat and Death	
	Immediata Cause (Final diaeese or condition	One week			
	resulting In death)  Due to (or es a consequence of):			10110 00001	
Examiner	Circhosis	One ucar			
Kam	Sequentially list conditions,  Due to (or es e consequence of):				
E	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that inflieledse or vertex to the consequence of):  Due to (or es e consequence of):  Due to (or as e consequence of):			Two week	
dici	that initieted events resulting in death) Last				
Completed by Physician/Medical	. Hepatitis C			One year	
lan					
ysic	Pert ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	23b. Did	tobacco uas cor	ntributs to the cause of death	
Ph	Hupertension	10	Yes 2 No	3 □ Probably 4 ₺ Unknow	
169		044 1994		24b. Were eutopsy findings	
etec	Upper aastroinestinal bleed	perf	en eutopsy ormed?	available prior to completion of ceuae	
ign.		_		of death?	
S	Atrial fibrillation	12	Yes 2□No	1 X Yas 2 No	
Be	Avaminar?	Deeth (Check only	one)		
10		ng Homa 5 Ras			
ion:	27. Menner of Death  1. Description   28b. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?		how injury occurr	ed	
Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 288 Place of Injury. At home farm street factors of the		(A)	0 10 10 11	
Ē	4 Homicide  28a. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify)	office 28f. Location (Street and Number or Rural Ro City or Town, Stete)			
2					
Medical	29a. Certifier  (Check only  (C	elece, end due to the occurred at the time,	cause(s) and ma date and plece, a	nnar as stated. and due to the cause(s)	
N N	one) end manner steted.  29b. Signeture and title of certifier 29c. License number		20d Data signar	1 (Month, Dey, Year)	
_					
	7125 00		April (		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North U Justina Wu Johns Hopkins Hoppital 600 North U Maruland 21287-9106	wolfe Str	ect, Bal	timore,	
ate	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture				
-	A Long to the second to the se				

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] amend item 10f per fh G785 7/26/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth . 2000 Month **Physician** 6, April 6:05 PM Ida Lucile Hannan /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Coath Examiner 3209 Britannia Court Annapolis Anne Arundel If Under 1 Year Hours Min. Oct Month Day, Year) 1 7. Age (In yrs. last birthday) 88 Yrs. Birthplaca (State or Foreign New York 5. Social Security Number 055-20-5141 **Funeral** Days Months Yrs. Director Usual Residence of Decedent the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a. Steta 10b. County "natural", or items 23s or 28s-f show edical Examiner must be notified at 1 Yas 2 No Director -NC SC Horry Surfside Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 17th Avenue, North 29574 29575 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 14. Race - American Indien, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny Injury or other traumatic event, the Medical Examinations. Black White etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: specify: White by 3 Ø Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Housewife Household 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pierre F. Cuaz Rose S. Jeantet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) George P. Hannan (Son) 3209 Britannia Ct., Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Buriel 2 Cremation 3 Nemoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/11/00 Orange Co., NY Woodlawn Cemetery 3111 Mountain Road 21. Signature of Fufferal Servide Licensee 22. Neme and Address of Facility Stallings Funeral Home, P.A. Pasadena, MD 21122 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fallers. List only and cause off each line. Approximate Interval Between Onset end Deeth **Physician** /Medical fmmediata Causa (Final disease or condition resulting in death) Examiner Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as e consequence of): 88 23b. Did tobacco use contributs to the cause of death? Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy Completed performed? 1 Yes 2 No 1 Tyes 2 No certificate Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) (SON) Hospitel: 1□ Yes 2□ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of To the Hospital or Attending Pi within 24 hours effer death. To the Funeral Director: After ti completely filled in by the funera After 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end dua to the cause(s) end mennar as stated. edical 29a. Certifier 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier

Registrar

State

CUMYS

31. Data filed (Month, Day,

AV Ste231 Annepolis MD 21401

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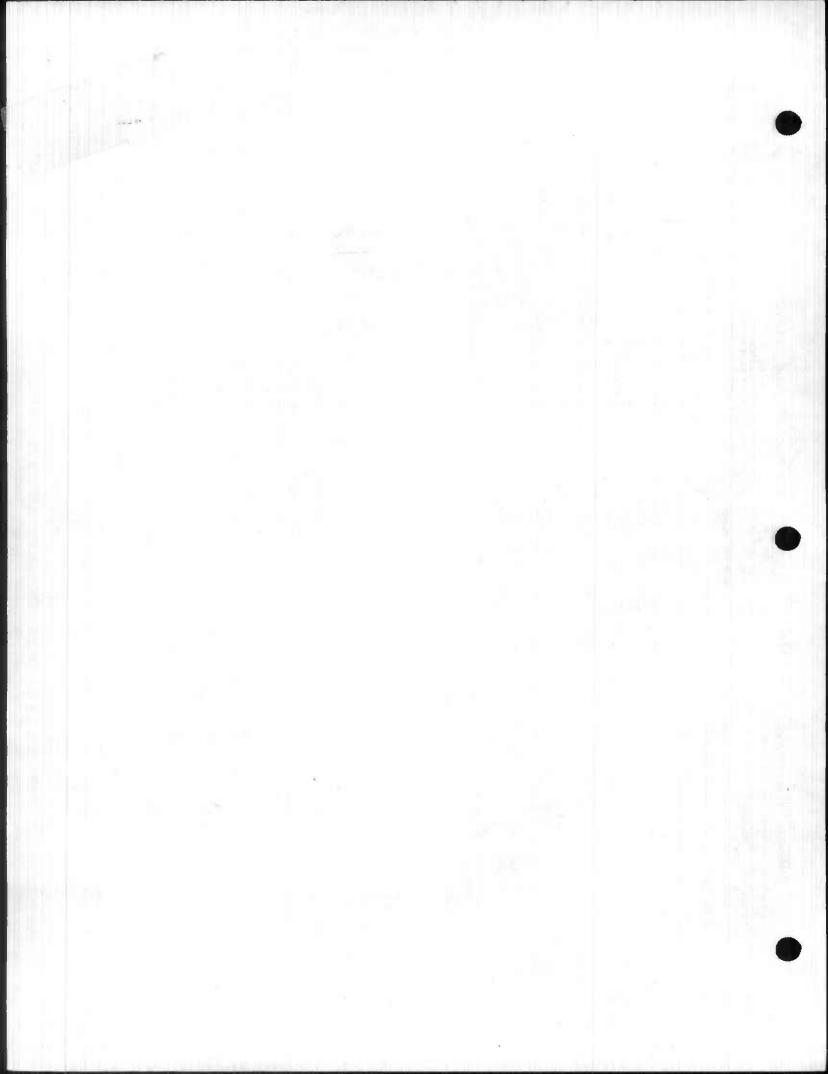
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32. Registrer's Signature

30. Nema and address of person who complated causa of death (frem 23a) (Type, Print)

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		Ce	rtificate of	Death		Reg. No.	)	1538	
Physician	1. Decedent's Name (First, Middla, Last)				2. Date of Dea Month MARCH		Year	3. Time of Death	
/Medical	IVORY JACOBS							10:30pm	
Examiner	4a Facility Nama (If not institution, giva street and no FUTURE CARE-CHESAPE		0.37	4b. City, Town, or Location of Death 4c. County of De ARNOLD ANNE				NDEL	
Funeral Director	5. Social Security Number 6. Sex 10XM 2□ F	7. Aga (In yrs. last birthday) 87 Yrs.	ga (In yrs. last birthday) If Under 1 Yaar If Under 24 H			8. Date of Birth (Month, Day, Year) 9. Birthplace (St.		ce (Steta or Foreign	
Le notified at	Usual Residence of Decedent				1.2-1.2	3.2	700111	CHRODI	
Pard at	MD ANN ARUNDEL	10c. City, Town or Lo	ocation				100	d. Inside City Limits 1 ☐ Yes 2 🕅 No	
or 28a-f	10e. Street and Number		10f. Zip Coda			10g. Citizen of W	/haf Countr	y?	
123a	854 DERBY FARMS DRI	1.44		U.S.	Α.				
odcal Examiner must be notified leted by Funeral Director	Armad F	2X No iva	Wes Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (Span, Mexican, Puarto Specify:	pecify Yas or No- Pican, atc.)	14. Race Blac Specify.	e - Amaricar k, Whita, at B		
rt, the Medical	15. Decedent's Education (Specify only highest grade completed,	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of wo			16b. Kind of Bu	siness/Indu	stry	
omple	Elementary/Secondary (0-12) College	1-40(5+)	LONGSHOREMAN			CERTIFIE	STEVADORE		
Corr	3rd 17. Father's Name (First, Middle, Last)	LONG	SHUREMA		o (First Middle	ddle, Maiden Surnama)			
aumatic avant, the To Be Co	SAM JACOBS			IDA GR		maioen Surnam	в.)		
or other traumatic avant, To Be C	19a. Informant's Neme/Relationship (Type, Print) ROSIE M. SMITH, DAU	and Number or Ru	ral Routa Numbe	outa Number, City or Town, State, Zip Code) SEVERN MD ,					
other t		20b. Place of Dispo		AKMS DE				0	
any injury or of once.	20a. Mathod of Disposition		matory or other pla		Deta 4-4-00	BALTIN		n, Stata	
any injury once.	21. Signature of Funeral Service Licensee	uneral							
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es the bu	Sequentially list conditions, if any, laading to immediate cause. Entar Underfying Ceuse (Diseasa or Injury thet initiated evants resulting in death) Lasf	Dua to (or as a conseq		-		TÀ		- 100	
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Be Be	25. Wes casa referred to medical axaminar?			26. Place of Dee	th (Check only o	ne)			
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mpletely Medic	one) 2 Medical Examiner: On the band man	asis of axamination and/or in nar stated.	vastigation, in my o	opinion, death occur	red at tha time,	data and placa,	and due to t	he cause(s)	
CO CO	29b. Signature end title of cartiflar	MO		0725		3/30	100		
	30. Nama and address of person who completed cause	se of death (Item 23a) (Type,	Print)	toleRd	C	· 6.20	l. ha	12114	
State	31. Data filed (Month, Day, Year)	Registrary Signeture	myers.	JUENA	sever	mar	FIVE	Danie	



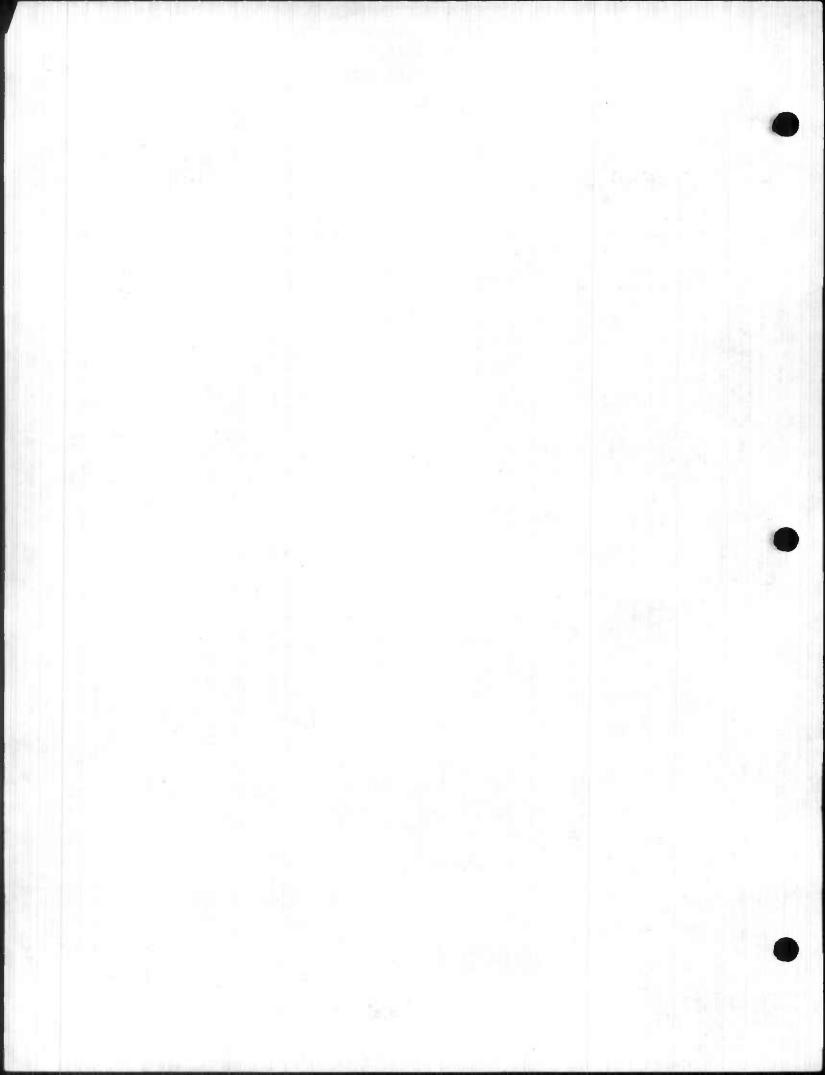
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death ERNEST JOHNSON 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HNGOW ERNOS MAR 22nd 2000 06:15PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Howard County General If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours HOM 20 F 88 Yrs. Director Md. 213-10-5317 March 7, 1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-t show Md. Howard Columbia 1 ☐ Yes 🏋 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10625 Green Mountain Circle 21044 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married Yes 2 No 8 21215-0020 1 ☐ Yes PNo Specify: Specify: Black þ the Medical Exa 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 bould be filed within 72 the allocations. Health and Mental Hygiene. Hyglena. other than Elementary/Secondary (0-12) College (1-4or 5+) Rockland Industries Executive Vice President Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be of Health and Menta Hern 27 to marked other traumatic as Rev. Bradley Johnson Fannie E. Crockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Johnnye S. Johnson wife 10625 Green Mountain Circle Columbia, Md. 21044 Baltimore, 20b. Place of Disposition (Name of 20a. Mathod of Disposition 20c. Location - City or Town, State etery, crematory or other place) Pages 1 urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) March 28 Baltimore, Md. Arbutus Memorial Park 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses May. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 6 nutter bei 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed the buriel-transit and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ P.O. Box 68760. physician Physician/Medical Due to (or as a consequence of): USB BS Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? detaci ate has been signed by page 2 should be detact 1 Y88 2000 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2500 1 Yes 2 No certificate Division of Vital Attending Physician: funeral director. Be 25. Was casa raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 Mpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Spatural 2 Accident death. 1 TYes 2 □ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

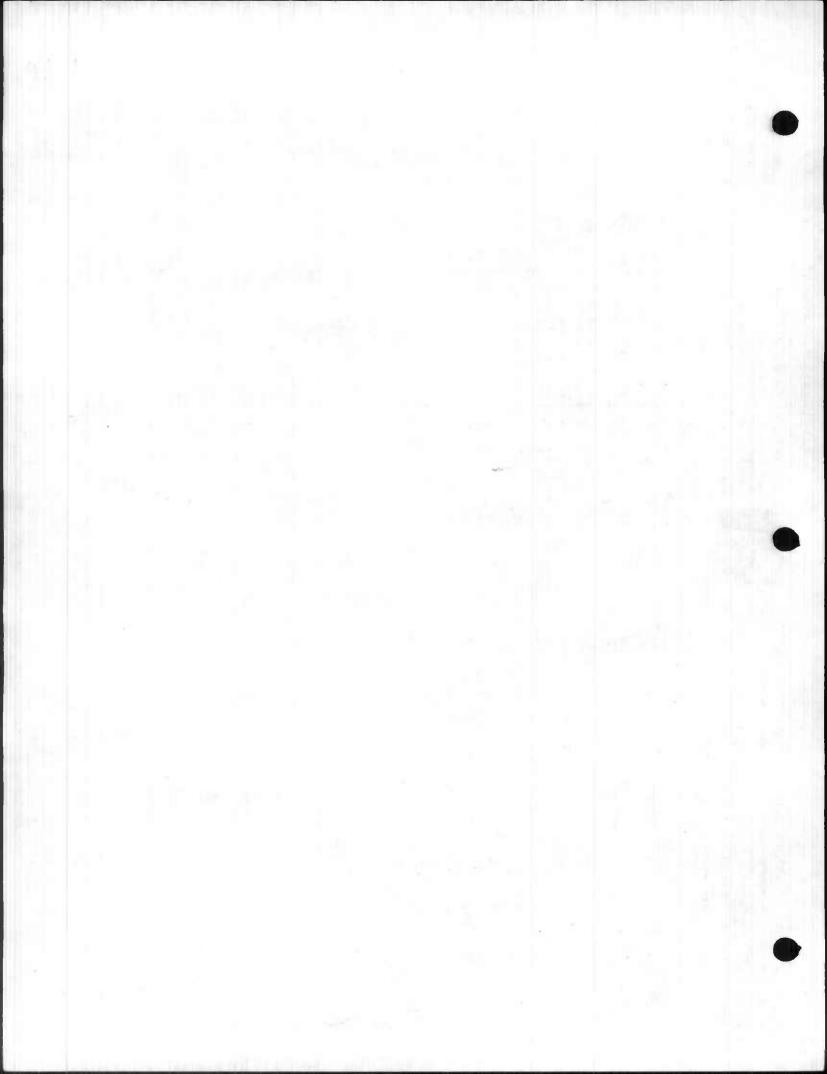
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MAR. 22nd 2000 D2892 18 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 10792 HUYORY RIDGE RE . COWMBIA MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Year Month Physician Stella Mary Jastrzebski 6, 7:45 p.m. 2000 April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Nursing Center Baltimore Co. Towson 8. Dete of Birth (Month, Dey, Year) Feb. 26, 1912 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Months Days Hours 88 Yrs. Pennsylvania 211-10-5325 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Pennsylvania Luzerne Co. Wilkes-Barre 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 385 E. Northampton Street 18702 United States Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 W No
K Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Floor Person Garment Industry 6 yrs. Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Sobieski Mary Gielczyski Stanley 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4139 Loch Lomond Drive Baltimore, MD 21236 **Tem 27** Michael E. Swengosh / Nephew 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stele St. Marys Maternity Cem. 4/10/2000 Wyoming, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Michael E. Canapp 5305 Harford Road 21214 LEONARD J. RUCK, INC. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner The law requires that the death certificate be executed burdel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical 9 Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown ρ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy performed? 1 ☐ Yas 2 ☐ No certificate Division of Vital 25. Was case referred to medical examine? or Attending Physician: 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this. 27. Manner of Death 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation s after des. 192Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide Hospital 24 hours a Funerel C 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stets. within 2 To the 29b. Signature-emorphical countries 29c. License number 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) to med 6-5mc 6207 31. Date filed (Month, Day, Year) APR 1 0 2000 32. Registrer's Signeture State Registrar

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Jastrzebski



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 Month Edward Harry Kelly April 7, 4:00 P.M. 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Rossville Baltimore H Under If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Sacurity Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. lest birthday) Birthplace (Steta or Foraign Country) Davs Months Yes 212-05-2940 Oct. 29, 1912 Maryland Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida Cltv Limits 1 ☐ Yes 2√ No Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 Maybin Circle 21117 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, atc. 1 Naver Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade Collega (1-4or 5+) -0-Meter Reader BG&E 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumame) Ethel Lotz Harry Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sarah Memphis - Sister-In-Law 300 Surrey Court; Fallston, Maryland 21047 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 □XBurlal 2 □ Cremation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 4/10/2000 Sykesville, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. М00869 ah. Et 8728 Liberty Road; Randallstown, Maryland 21133 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, of haart failure. List only one cause on each lina. Approximate Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 N No 1 Yes 25. Was cese referred to medical examiner? 26. Place of Daath (Chack only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how Injury occurred 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Sulcide 6 Could not be determined

The law requires that the death certificate be executed pue Box 68760, the attending physician P.O. signed by t Division of Vital Records, peen this certificate has Physician: After Attending death. after death 6

Examiner Physician/Medical by Completed Be 2 Certification:

**Physician** 

/Medicai

**Examiner** 

Directo

Funeral

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Completed

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**Funeral** 

Director

Show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mast be notified at

al Hygiene.

Mental

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permit. Pages I Department of H Important: If its eny injury or ot once.

**Physician** /Medicai

**Examiner** 

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0020

altimore,

Kelly

Medical

State Registrar 29b. Signature and title of certifier

29c. Licansa number (2) 25391

Cartifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Date signed (Month, Dey, Year) 4-10-2000

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name and addrass of person of death (Item 28a) (Type, Print) 5601-Loch

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

31. Date filed (Month, Day, Year)

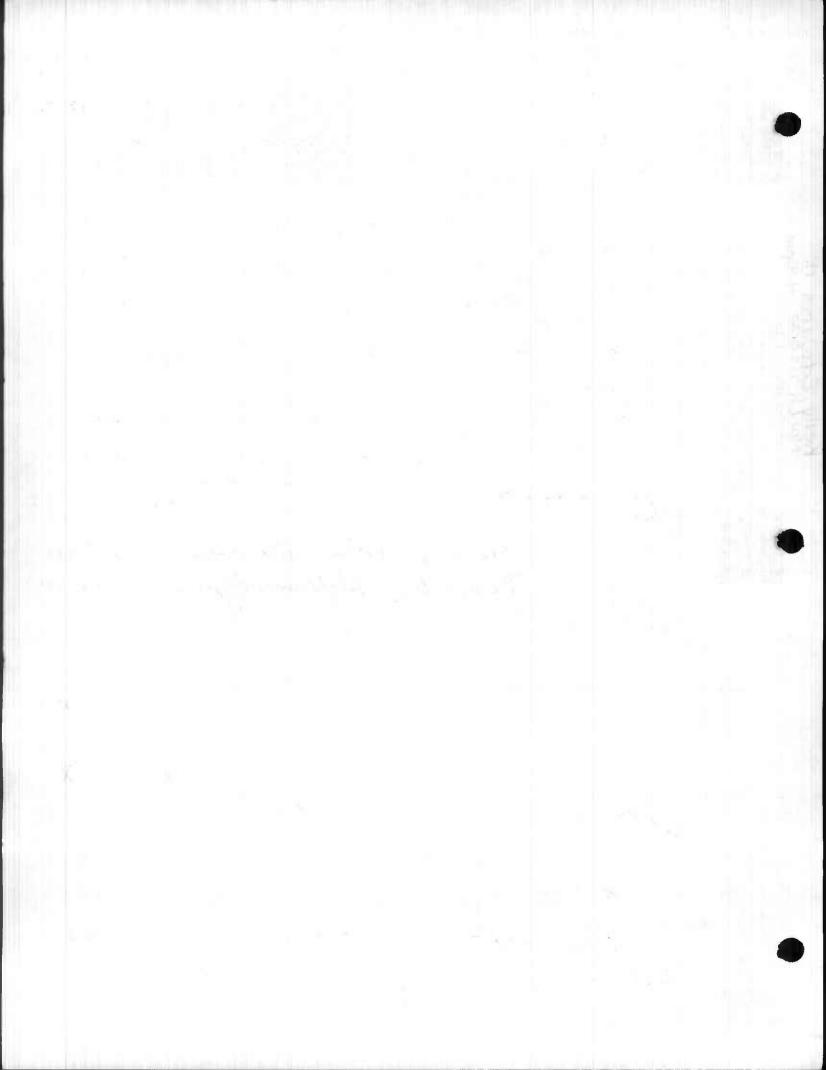
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29a. Cartifier (Check only one)

32. Registrar's Signature oaks

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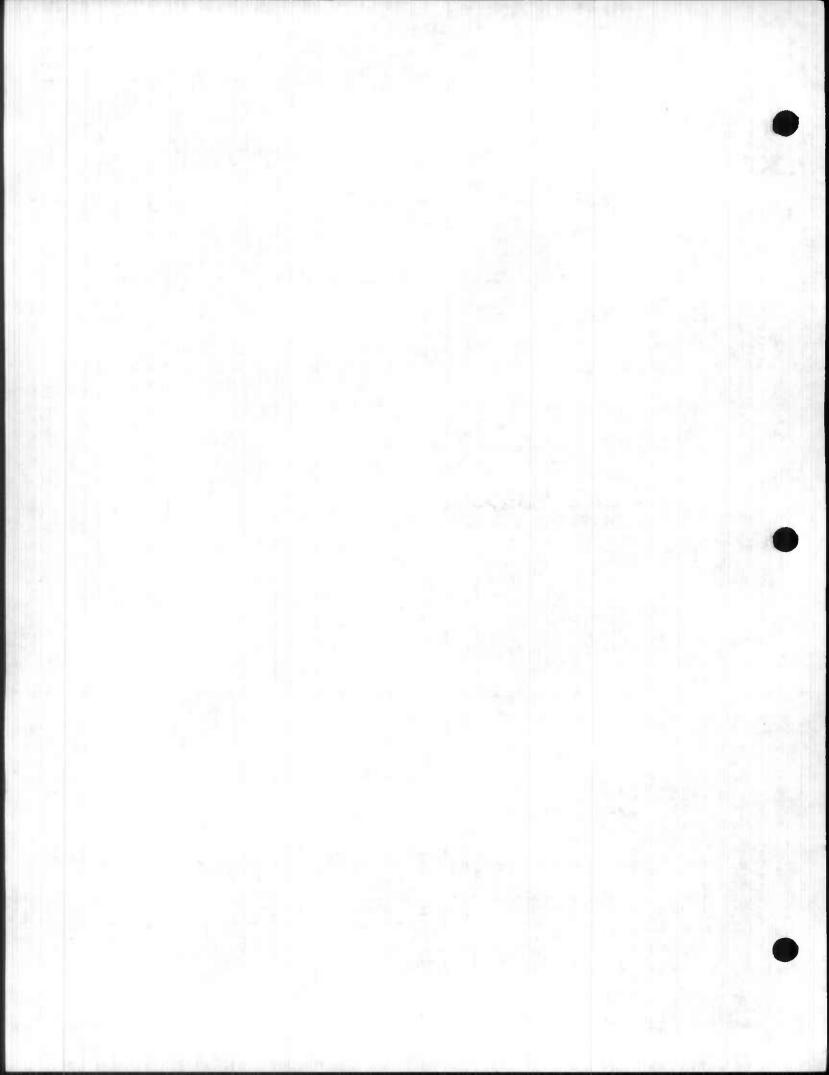


# Kershner, Edith

DHMH 16 Rev 6/95

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Physicia	an		Decedent's Name (First, Middle, Last)							2. Dete of Death Month April 7,			3. Time of Death	
/Medic	al	Edith Marie Ker  4a Fecility Neme (If not institution, g		mbad				4b City To	wn or Lo	April Death	7, Day 2000		11:30 PM	
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Funeral			Sex		rs. last birthd	ey) If Under		If Under	24 Hrs.	8. Date of Birth		9. Birtho	lace (Stete or Foreign	
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pus B.		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or	Location						1	0d. Inside City Limits	
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r 28s		10e. Sfreef and Number 10f. Zip Code								log. Citizen of W	hat Coun	itry?		
death with the Maryland rns 23s or 28s-f show r.mast be notified at		3939 Roland Avenue				21211					U.S.A.			
	uner	11. Marital Status	12. Was Dec Armed Fo	20002	U,S. 1	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto			ecify Yes or No- Rican, etc.)		- Americ k, White,	an Indian, etc.		
0020 hours after ural', or its	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Gr	1 Yes 2 No WWII			1 ☐ Yes 2 ☐ No Specify:				Specify	Specify: White		
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215 nn 72 m 72 Media	plet	(Specify only highest g Elementary/Secondary (0-12)		ade completed)  College (1-4or 5+)		(Give kind of work done life. DO NOT use retire		ne during most of working red)						
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and 2 should and 27 is me traum		19e. Informent's Neme/Reletionship Lynn P. Berry (	(Type, Print) Niece)								r, City or Town, e Woodla		Code) TX 77382	
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Ball permit permit permit permit permit permit		21. Signature of Funeral Service Lio	Signature of Funeral Service Licensee 22. Name and Address of Facility Roll 22. Name and Address of Facility										irectors,Ir 21133	
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  e. Cerebro Vascular A							AC	cidel	17	1	2 Wilning	
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P.O.	Physician/Med	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									bably 42Unknown			
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of Vita Physician: this certific	2	1 ☐ Yes 2 ☑ No				etient 3 DC	A		rsing Ho		lenca 6 DOth		(ע	
On On Oil	tion	27. Manner of Deeth  1 Netural 5 Pending investigat	(Mor	28a. Date of Injury (Month, Dey Year)   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No					No	28d. Describe how injury occurred				
Atten Atten ar deal by the	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide	be 28e. Place	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)  28f. Location (Street end Number or Rural Recognition)						al Route Number,				
Di Hospital or 24 hours afte Funeral Dir etely filled in		29e. Certifier 119 Certifying I	Physician: To the	hest of my li	h aphalwon	eath occurred	at the ti	ime date an	d place	and due to the	Pause(s) and ma	a se senne	teted	
n 24 h	edical	(Check only 2 Medical Expone)	miner: On the b	asis of examiner stated.	ination and/o	r investigation	in my	opinion, dee	th occur	red at the time,	date and place,	and due to	the cause(s)	
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1/2 X,		30. Neme and address of person wh	4 3007 E	No	rtho	Pe, Print) F	21	kuc	u	Balt	Apr. "	21	214	
Sta Registra		31. Date filed (Month, Dey, Year) APR 1 0 2000	32. F	Registrar's Sig	Spar	Ks								

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month auronce AC ZMAY 4a Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Baltimore 100 H More If Under 24 Hrs. If Under Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 218,26.3488 Months Min. 18M 20 F Hours Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 W. Ostend Street 21230 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant 12 Fire Dept. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Maxilliam F. Kaczmarek Margaret Dailey M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 W. Ostend Street, Baltimore, Md. 21230 Loretta Roberts (Sister) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 15 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) New Cathedral Cemetery 4/11/2000 Baltimore, Md. 22. Name and Address of Fecility McCully-Polyniak Funeral Home P.A. 21. Signature of Funerel Service Licenses 130 E. Fort Ave. Baltimore, Md. 21230 men 23a. Part1. Enter the disease, or complications the daused the doubt. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause of each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 2 1 No 2 No 1 ☐ Yes 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3D DOA 1 ☐ inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 (PNatural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined

The law requires that the death certificate be asscuted Box 68760, Records, P.O. Division of Vitai Attending Physician: he Hospital or Attending Ph In 24 hours efter deeth. he Funeral Director: After th pletely filled in by the funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

Items 23a

permit. Pages 1 and 2 ahouid be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or him eny injury or other traumatic event, the Mades Examples on the contract of the contract of

Physician /Medical

Examiner

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Physician/Medical

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Completed

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Certification: To

edical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Baitimore, Maryland 21215-0020

Director

Funeral

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Completed

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the Maryland

completely within 2 State

Registrar

KNO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe 29d. Date signed (Month, Day, Year) 00

281. Location (Street and Number or Rural Route Number, City or Town, State)

22 S. Greene Street Baltimore, Md. 21201 University Of Md.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

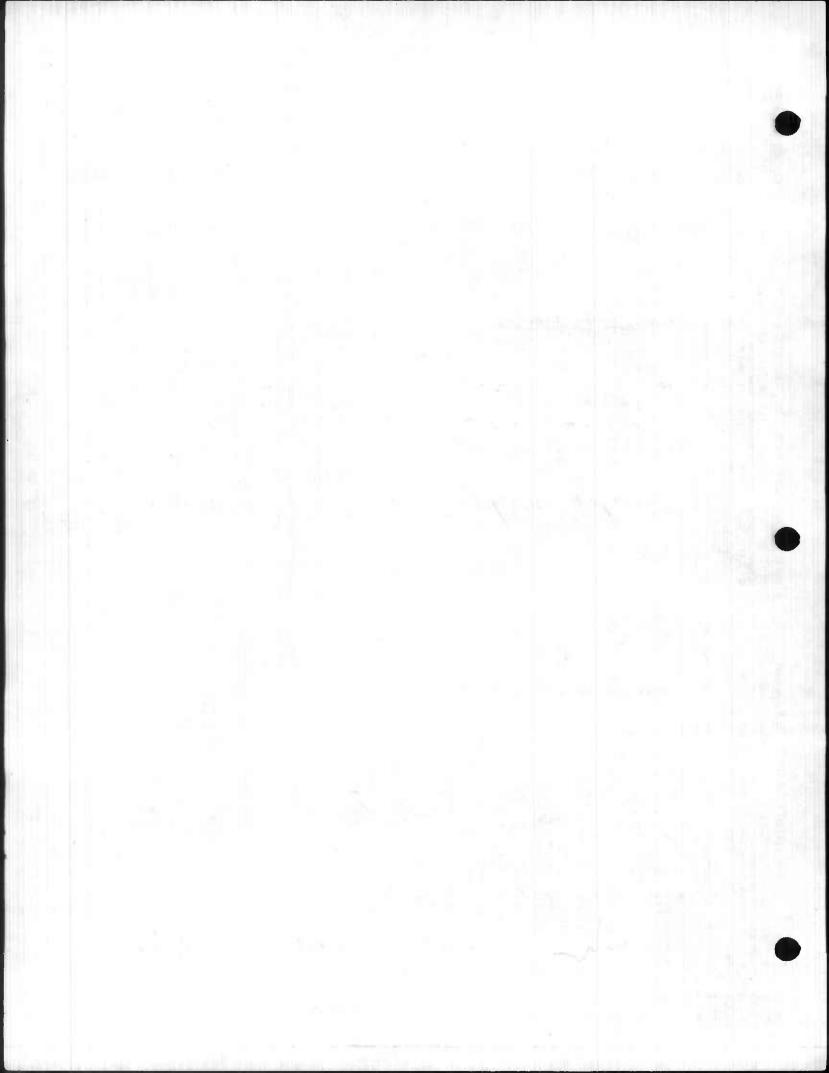
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier Dick C. Kuo

32. Registrar's Signature onks Geneva

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1238m Physician lla 2000 Samows 4a Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rossville HCR Manor 5. Social Security Number are If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 10 M 20 F 165-20-1707 CNNA Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits mo BALTIMORE 1 Yes 2 No MIDDLE Funeral Director r 28e-f 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours effect death with interior of Hallin and Merial Hygiena. Int: If Nem 27 is marked other than "natural", or from 23a or into or other than the Merial avent, the Merial and the market in the Merial and the Merial and the Merial and Is/Ans 21220-2243 RD Carroll 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D/No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 20 No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOME OWN HOMEMAKER Baitimore, Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) 8 BYORICK FRANCES GORALSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/220 19a. Informant's Name/Relationship (Type, Print) KAMOWSKI 318 ARROLL ISLAND MIDDLE RIVER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4/13/00 Depertment of Important: If eny Injury or page. MARY NANTICOKE, PA 18634 of CZESTOCHOWA 4 Donation 5 Other (Specify) 22. Name and Address of Facility CONNELLY FUNCIAL 7/10 Sollers Point Home of bondall, P.A. 21. Signature of Funeral Service Liceny BALTO. 7/10 MD. 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture, List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner To the Mospital or Attanding Physician: The law requires that the death cartificate be associted within & Ahours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? B 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,/Day, Year) 30. Name and address of person who complet ed cause of death (Item 23a) (Type, Print) JAMES EBELING

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

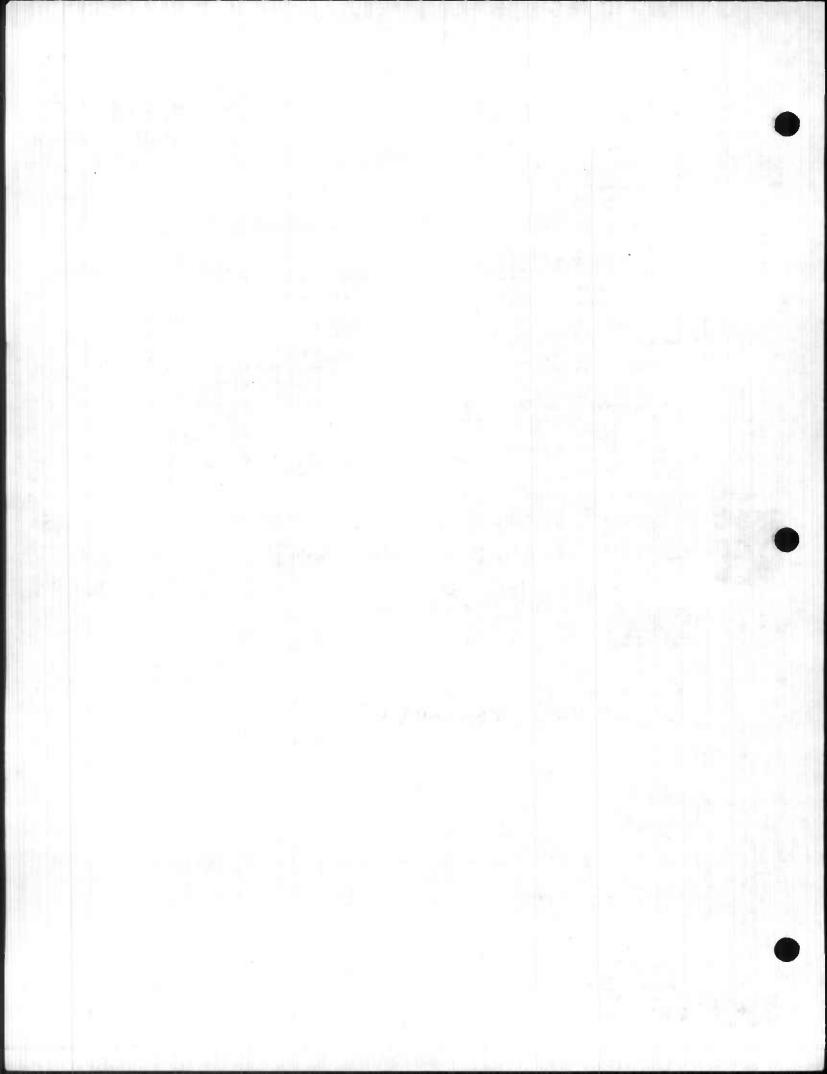
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MD

32. Registrer's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death APRIL **Physician** 2000 10:12 PM David J. Kessler /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IEN BURNIE ARUNDEL HOSPITAL AA COUNTY If Under 24 Hrs. 6. Sex 1 M 2 □ F If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Months Days 42 Yrs. 220-56-0380 October 13,1957 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ♥ No Funeral Director Maryland | Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 998 Pebblestone Road 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: py Specify: USA 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Electrician 12 Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Christian G. Kessler Ann T. Blandin 19a. Informent'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Leslie Kessler - Wife 998 Pebblestone Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. April 7 Baltimore, MD 21. Signeture of Funeral Service Licture 22. Name end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications that caused the dishock, or heert feilure. List only one cause on each line eth. Do not enter the mode of dying, such es cardiac or respiratory errest, Interval Between Onset and Daath Immediate Cause (Finel ARRHYTHMIA disease or condition resulting in death) Due to (or as a consequence of): Examiner CARDIAC APPEST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were eutopsy findings evailable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Daeth (Check only one) To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 LER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760, physician at the burial signed by the a Records. P.O. this certificate Division of Vital Attending Physician: After To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu death.

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: if item 27 Is marked other than "natural", or item any injury or other traumatic avant, the Hoces pages.

Physician /Medical

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Registrar

Candace Chandler mo 31. Date filed (Month, Day, Year) State

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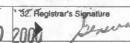
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

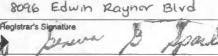
4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier





Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and menner estated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and menner estated.

29c. License number

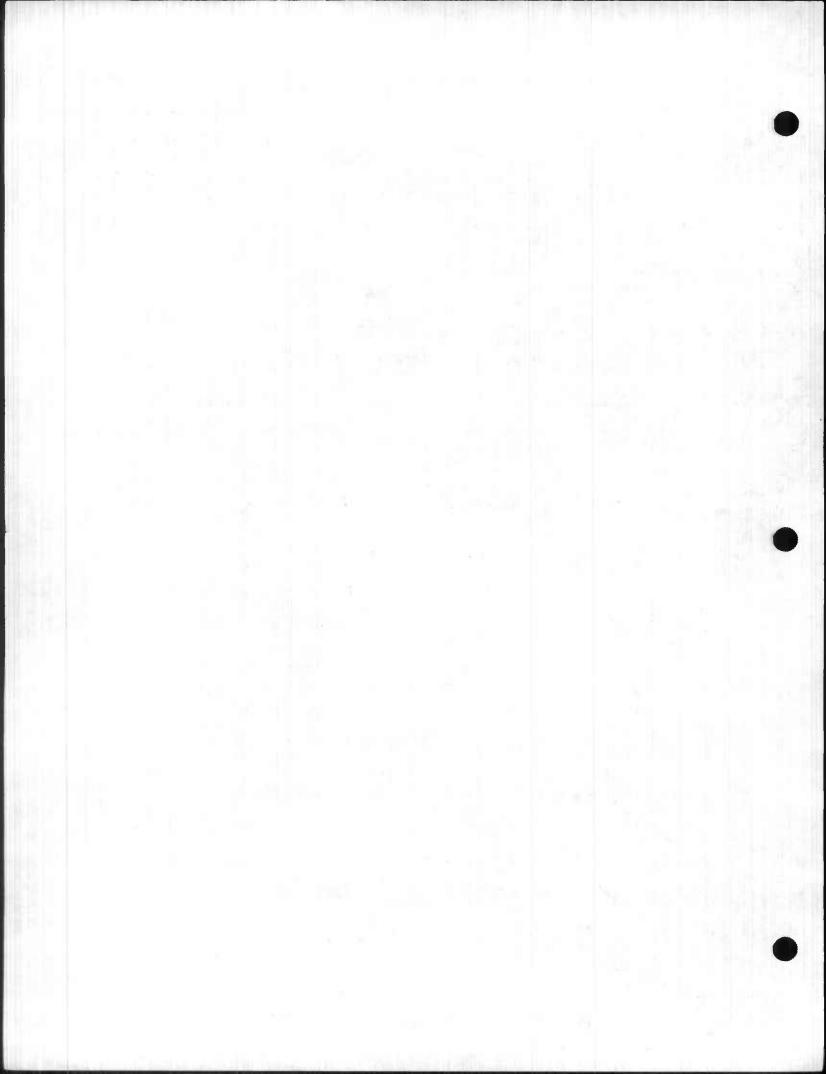
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29d. Dete signed (Month, Dey, Year)

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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11546 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death April 8, 2:15 a.m. Sterling Edward Leese 4e Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Genesis Eldercare Randallstown Months Days Hours Min. B. Data of Birth (Month, Day, Year) July 9, 1924 6. Sex 16 M 2 F 5. Social Security Number 9. Birthplaca (State or Foreign Country) Melrose, Md. 7. Age (In yrs. last birthday) Months Yrs. 216-16-1862 Usuel Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Pa. York Hanover 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Gardenia Drive 17331 U.S.A. 12. Wes Decedent Ever in U,S. Amed Forces? 1 △ Yas 2 □ No. If Yes, Give W.W.II Yaer or Detas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Chief Warrent Officer Military U.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grover Leese Lulu Leese 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Doris V. Leese 50 Gardenia Dr. Hanover, Pa. 17331 - wife 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition cemetery, cremetory or other place) 1 Buriel 2 □ Cramation 3 □ Removal from State St. David's Cem. April 11, 2000 Hanover, Pa. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Chapel 3296 Charmil Dr. Manchester, Md. 21102 23a. Part Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, o heart failure. List only one cause on each line. Approximeta Interval Between Onset end Death Immediate Causa (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NEION 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death

**Physician** /Medical Examiner burial-trans De exect P.O. Box 68760.

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "n any Injury or other traumatic event, the Med

Director

Funeral

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be Certification: To

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Records.

Division of Vitai

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Registrar

(Check only one)

29a. Certifier

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2 Accident

3 Suicida

4 Homicida

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and title A Cont

28a. Data of Injury (Month, Day Year) 5 Panding investigetion 6 Could not be

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

eted cause of death (Item 23a) (Type, Print)

29c. License number

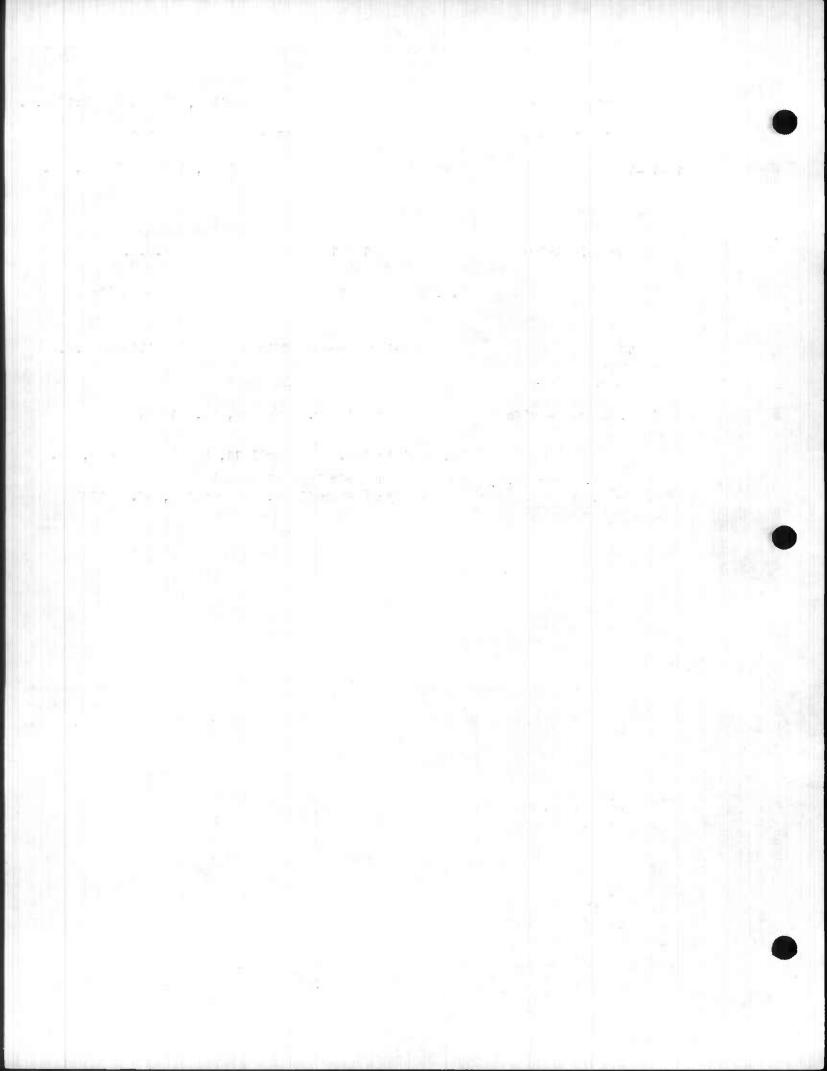
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31. Date filed (Month, Day, Year)

2000

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**DHMH 16 Ray 6/95** 



## Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1237 APRIL 2000 PM 6. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** WAY BALTIMORE 6200 CARBOR 5. Social Security Number 245-86-5833 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F Months Days Hours Yrs. **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Teres 2 No Director MORRE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 2 Funeral . Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cyban, Mexican, Puerto Rican, etc.) American Indian 14 Race "natural", or items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or have injury or other traumation. I∏Yes 2∭ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No py 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) NA 16b. Kind of Business/Industry econdary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Retationship (Type, Print) Baltimore, 40 20c. Location - City or Town, State Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licansee NO 2121 638 sulmor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Cardiomygpa Examiner Physician/Medical Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events signed by the attending physician and die detached for use as the burial-tran Due to (or as a consequence of) certificate be exec Box 68760 Due to (or as a consequence of): resulting in death) Last P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Renal Insufficiency hes Ves Yes Yes 2 No 2 No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 10 XXYes 2 No 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred edical Certification: Injury at Work? 1 Natural 5 Pending investigation s after death.

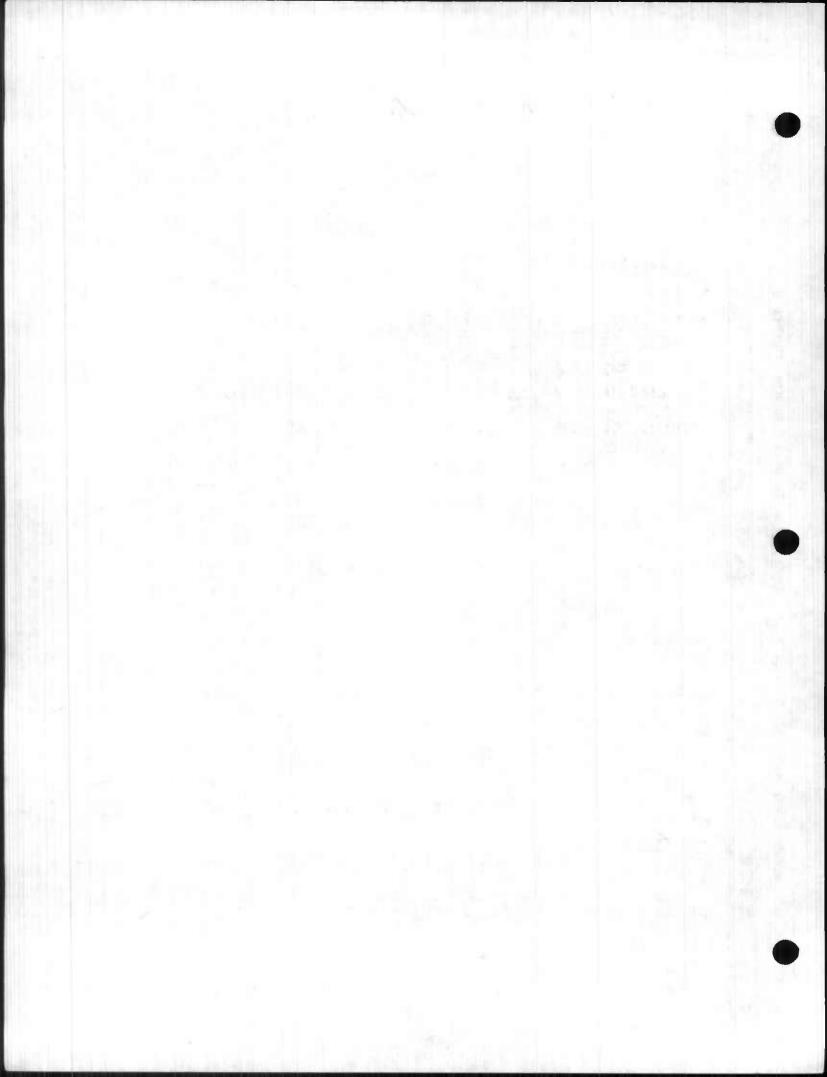
I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier O.C.M.E. APRIL 7, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 hutem 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

source

**DHMH 16 Rev 6/95** 

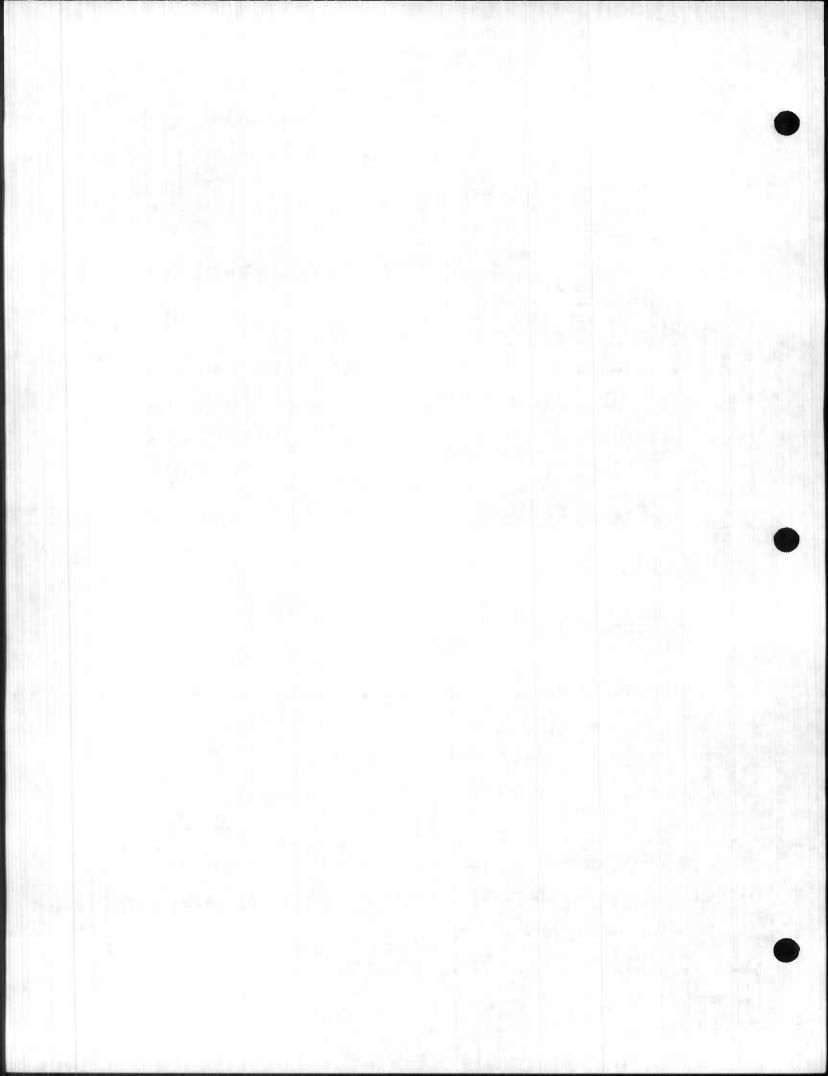
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State of Maryland / Department of Health and Mental Hygiene 00 11548.

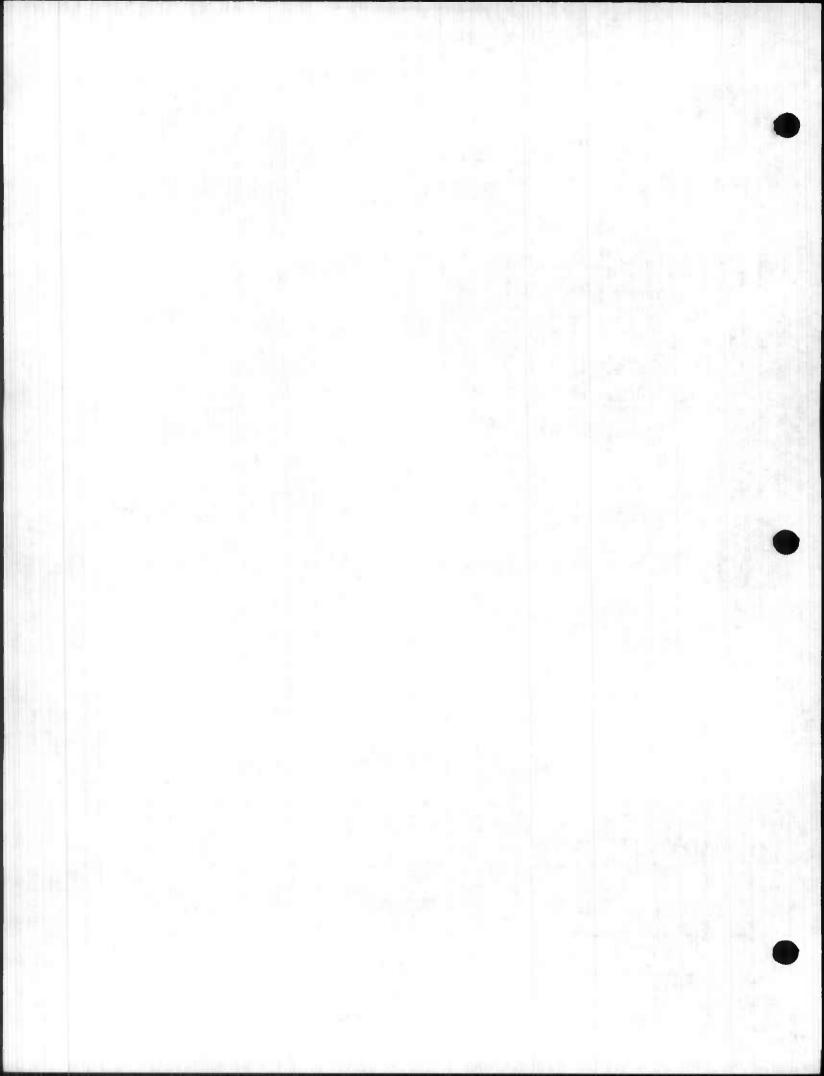
			Certificate	of Death		leg. No.	0 1104		
<b>D</b> lauriaian	1. Decedent's Name (First, Middle, Las				2. Data of Dea		3. Tima of Deat		
Physician /Medical	Florence L.	Martin			April	6,20	1 7 1 1 4		
Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	4c. County of	Death		
72	Ridgeway Manor Nur			Catons		Baltim			
Funeral	5. Social Security Number 6. Se	TM 200 E	Months	Yaar If Undar 24 H Days Hours M		y, Year) 9.	. Birthplaca (Stata or For Country)		
Director	212-26-2666	95	Yrs.		Jan. 3		[aryland		
pur *	Usual Residence of Decedent  10a. Stata 10b. County	10c. City	, Town or Location				10d. Inside City Lin		
Aaryli S S S S S S S S S S S S S S S S S S S	N11/-	n 1					1 X Yes 2 □		
vith the Ma to 28s-f s be notified Director	Maryland n/a	ват	timore 10f. Zip C	'ode		10g. Citizen of Wha	at Country?		
With Page 10	5507 W 1 .: 1 0 .:1	South		228		USA			
within 72 hours after death with the Maryland ene.  Than 'netural', or Neme 23e or 28e-f show the Medical Everyfree must be notified at ampleted by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S				Amarican Indian,			
Fun Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		nt of Hispanic Origin? y Cuban, Mexican, Pu	èrto Rican, atc.)	Black, 1	White, etc.		
il', o	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Dates:	1 Yes 2	1 ☐ Yes 2 ② No Specify:			White		
d within 72 hours at glane. In then "natural", or the "natural", or the Windlea Extra	15. Decedent's Edu	ucation	16a. Decedent's Usual	. Decedent's Usual Occupation			ness/Industry		
ed within 72 ho yglene. er then "natur rt, the Medical Completed	(Specify only highest grad	College (1-4or 5+)	(Giva kind of work done during most o life. DO NOT use retired)		vorking				
Hyglene.  Hyglene.  And, the Manner, the M	6	0	Homemaker			Ownhome			
be filled d other event, the	17. Fathar's Nama (First, Middle, Last)	A PER LA PRINCIPAL PRINCIP		18. Mother's N	lame (First, Middle,	Maiden Sumema)			
	Robert W. Ridinger	:		Blancl	ne E. Ste	n	S Year		
2 should and Men in marks in m	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailing Address (	Street and Number or	Rural Route Numbe	r, City or Town, Ste	ete, Zip Code) 2122		
<b>在有限</b> 6	Jacqueline M. Bend	ler / Niece	1237 South	Grantley S	Street, B	altimore,	Maryland		
子が	20a. Method of Disposition	0.0	ace of Disposition (Name	e of per place)	Date	20c. Location - Cit	y or Town, State		
Pages nert of int. If the iry or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)	Baltimore	e, Maryland						
permit. Pages 1 at Department of Hea Important: If Item any Injury or othe otice.	21. Signature of Funeral Service Licent		Cathedral	Address of Facility					
SEEES	1KKC	0		Funeral Ho		nore Mar	yland, 2122		
	23a. Part1. Enter tha disaase, or comp	lications that caused the death					Approximete		
Physician	shock, or heart failure. List only o	ne cause on each line.					Onset and Death		
/Medical	Immediata Cause (Final disease or condition	Waraco	tral Infa	mites			J. 121		
Examiner	resulting in death)	-	as a consequence of):	.01.0.(			- mmeal out		
ةِ السَّاسِةِ ا		, 550.10 (61	as a sorrosquarion or,						
death certificate be executed teathering physician and set for use as the burial-transit siclan/Medical Examiner	Sequentially list conditions	b. Due to (or	Due to (or as a consequenca of):						
Ex Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
ficete be explicate by physician as the buria	Cause (Disease or Injury that initiated events resulting in death) Last	C Due to (or	as a consequance of):						
ing ph e as th	resulting in dealin, cast								
attending for use a	110000000000000000000000000000000000000	d							
the at hed for	Pert ff. Other eigniffcant conditions co	ntributing to death but not resu	tting in the underlying ca	use given in Part I.	23b. Dld 1	obacco use contri	bute to the cause of de		
F 99 F					10	Yes 20 No 3	Probably 4 Unki		
b s th									
sicien: The law requires certificate hes been sign irector, page 2 should be be Completed by						en autopsy med?	<ol> <li>Were autopsy findin available prior to</li> </ol>		
lew respectively					•••		of death?		
The le					101	as all No	1 ☐ Yes 2月 No		
certificate rector, pa	25. Was case referred to medical			26. Place of I	Death (Check only o	ne)			
Physicien: this certific ral director, To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 DOA	Other: 45 Nursing	Home 5 Resid	lenca 6 Other	(Specify)		
g Physics of this neral di	27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of 28	c. Injury at Work?	28d. Describe I	now injury occurrad			
f or Attending I after death. Director: After d in by the funer	1 Natural 5 Pending 2 Accident Invastigation	(Month, Dey Year) Injury Work?  M 1 Yes 2 No							
or Attend after death Director: d in by the	3 Suicide 6 Could not be determined	28e. Placa of Injury - At ho- building, etc. (Specify	me, farm, street, factory,	offica	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
tal or Attending P is after death.  In Director: After led in by the funer;  Certification:			,						
To the Hospital or At within 24 hours after To the Funeral Direct completely filled in by Medical Certiff	29e. Certifier (Check only 2 Medical Exam)	elclan: To the best of my know iner: On the basis of examinati	viedge, death occurred at	the time, date and pla	aca, and due to the	cause(s) and menn	er as stated.		
the H hin 24 the Fu nplete	one)	and manner stated.							
With Tot	29b. Signature end title of continu	11/201	29c.	License number		29d. Date signed (	Month, Day, Year)		
10	Salank h	while M	AJ C	1002331	0)	4/7	100		
00	30. Name and address of person who co	ompleted causa of deeth (Item	23a) (Type, Print)	1	11 - 5	011-	14.0		
	atrick Wil	White 7/61	Tarder Cho	ruhane.	# 200 H	Balton	my MJ) 212		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ura la 1	1					
Registrar	APR 1 0 2	ann Deput	Di M	arks					



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L			JR.					Month	Day	Yeer		
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	5 NA 5. Social Security N		ex 7	. Age (In yrs. I	ast birthday)	If Under 1 Yeer	If Under 24 Hrs.	8. Date of Birth	h		lace (Stete or Fore	
-	218-18-1 Usuel Residence o	1815 1	ØM 2□ F	75	Yrs.	Months Days	Hours Min.	(Month, Day		Coun	lace (State or Fore try) SC	
⊢	10a. State	10b. County			, Town or Loc		2537			11	0d. fnside City Lim	
L	MD	BALTIMO										
Н	10e. Street and Nu				10f. Zip Code				10g. Citizen of V		try?	
	1219 PAR	LK HGTS.	AVENUE			212				JSA a - Americ		
		rried 2 Married	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es?	□ No 1□ Yes 2☑ No Sp			spenic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) Specify:			Bleck, White, etc.  Specify: BLACK	
	(Sna	15. Decedent's Ed	lucation		16a. Deced	ent's Usuel Occup	pation	rina	16b. Kind of Bu	siness/Inc	Justry	
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	10 TH GR		NA		STEE	EL WOR					n STEEL	
		(First, Middle, Last)					18. Mother's Nam			(0)		
-	EARL MIL			C	I		BEULAH					
		Name/Reletionship			4010	0.0.11	end Number or Rui			Stete, Zip	Code)	
	KATHRYN 20a. Method of Dis		S WIFE			PAKK HO	IB. AVE.	BALTO Date	20c. Location -	21 200 City or To	State	
•	1 D Buriel 2	Cremetion 3		ete	metery, crem	etory or other ple						
_		5 Other (Specify		CRO	MUSILL		METERY 14	1-10-00	CROWN:	SVILL	E, MD	
	21. Signature of Fu	uneral Service Licen	S00		VA VA	Neme and Addre	GREENE	FUNERA	L SERVI	Œ		
23e. Pert1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximate interval Between												
8	Sequentially list co if eny, leading to it cause. Enter Und Ceuse (Diseese of that initiated event resulting in death)	derlying or injury ats	b	Hy	as a consequence of the conseque			Ų,				
			V									
	Pert II. Other signi	iffcant conditions of	ontributing to dea	th but not resu	ilting in the ur	derlying cause gi	ven in Part I.	23b. Dfd 1	tobacco uae coi	ntribute to	o the cause of dea	
	Pert II. Other signi	ificant conditions of	ontributing to dea	th but not resu	ilting in the un	derlying cause gi	ven in Part I.		tobacco use co Yes 2 No			
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23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or typical failure. List only one cause on each line.  Approximate the mode of dying, such as cardiac or respiratory arrest, and interval Benderick.										
art failure. Lis	st only one cause	on each line.	ath. Do not er	iter the mode of d	rying, such as cardia	c or respiratory ar	rest,	tnterval Between Onsat and Daath		
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Immediate Cause (Final disease or condition a								24 hrs.		
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rieno	Netal	stay Duese.					1 Pres 2 No 3 Probably 4			
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No	100000	1 Inpatient 2		SHI SLI DOA	4 LI Nursing I	·	ience 6 Other			
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at						250. Dascribe	now injury occurred			
5 Pend	tigation			M 1	Yes 2 No		Anti-			
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State Registrar

MI 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

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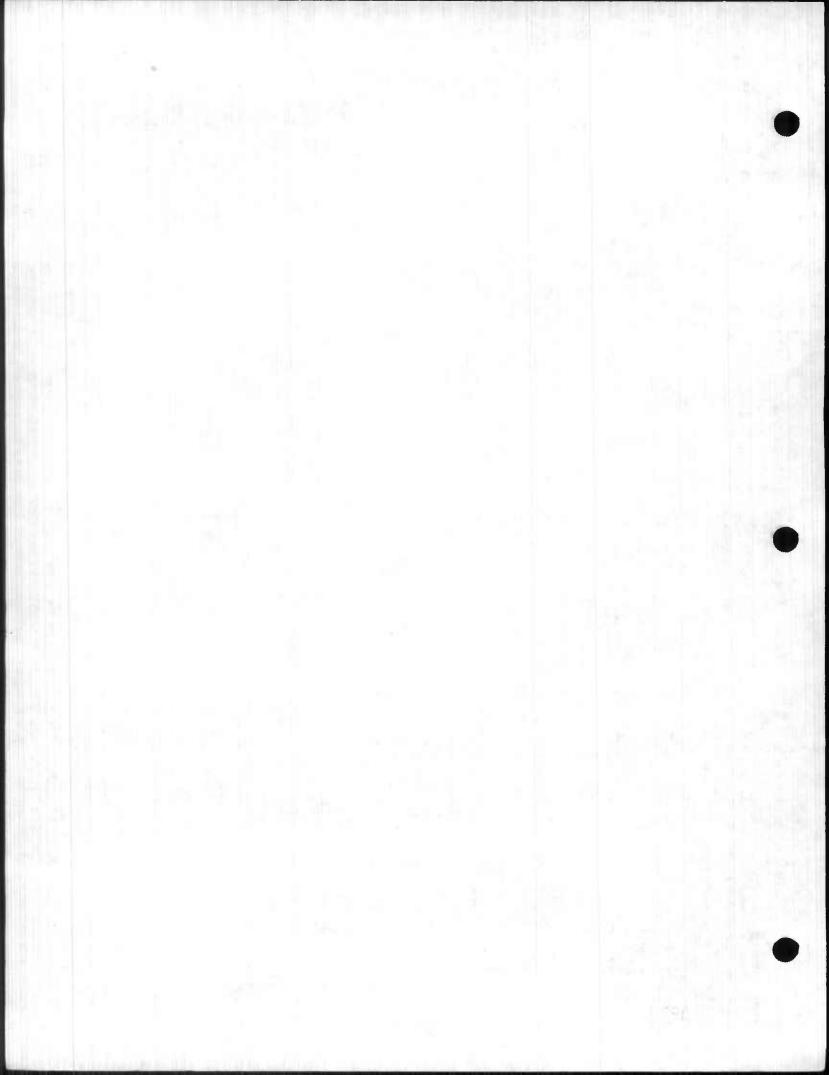
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O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

APRIL 7, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Dete of Deeth Month **Physician** Edward Raileau 7:22 AM Apri 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Randallstown Hospital Center BALLIMORE If Under 1 Yaar | If Undar 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12M 20 F Months Dava Hours 218-28-8199 Usual Residence of Deceden Director 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limite the Maryla 1 765 2 No Funeral Director SALEIMORE 28a-f n 23a or 28a-f munt be notifie 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 68. 1201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) Was Decerlent Ever in U.S. American Indian 11. Meritel Status Armed Forces?

1 Tes 2 No
If Yes, Give
Year or Datas: Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after in ont of Health and Mertal Hyglene, with filem 27 is marked other than "natural", or its with or other transmitted event, the Medical Examination by or other transmitted event, the Medical Examination 1 Never Married 2 Merried 1 Yas 2 No Specify: BLA Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RIGCLAYER 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Symame) Be dunko To 20b. Place of Disposition (Name cemetery, crematory or oth 20a. Method of Ottoposition 20c Led 1 Deformal 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility /404) ELL 21. Signature of Funeral Service Limit 23a. Pern Enter the disease, or complications that caused the death. Do not enter the shock, or heart tailura. List only one cause on each line. **Approximata** Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) · Cardiopulmonary failure >72 hours Examiner Due to (or as a consequence of): Examiner 2 weeks Systemic inflammatory syndrome response burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Recurrent bacterial endocarditis 2. weeks Be Completed by Physician/Medical Dua to (or as a consequence of): USB 25 Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Chronic renal 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Diabetes mellitus certificate has Hypertension
25. Was case/refarred to medical examiner? 1 ☐ Yea 2 No 1 □ Yes 2 □ No or Attanding Physician: funeral director, 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 DNatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Cortifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the besis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. the th 29b. Signature and titla of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 Booton MC

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State Registrar

31. Data filed (Month, Day, Year) APR 1 0 2000

Boston

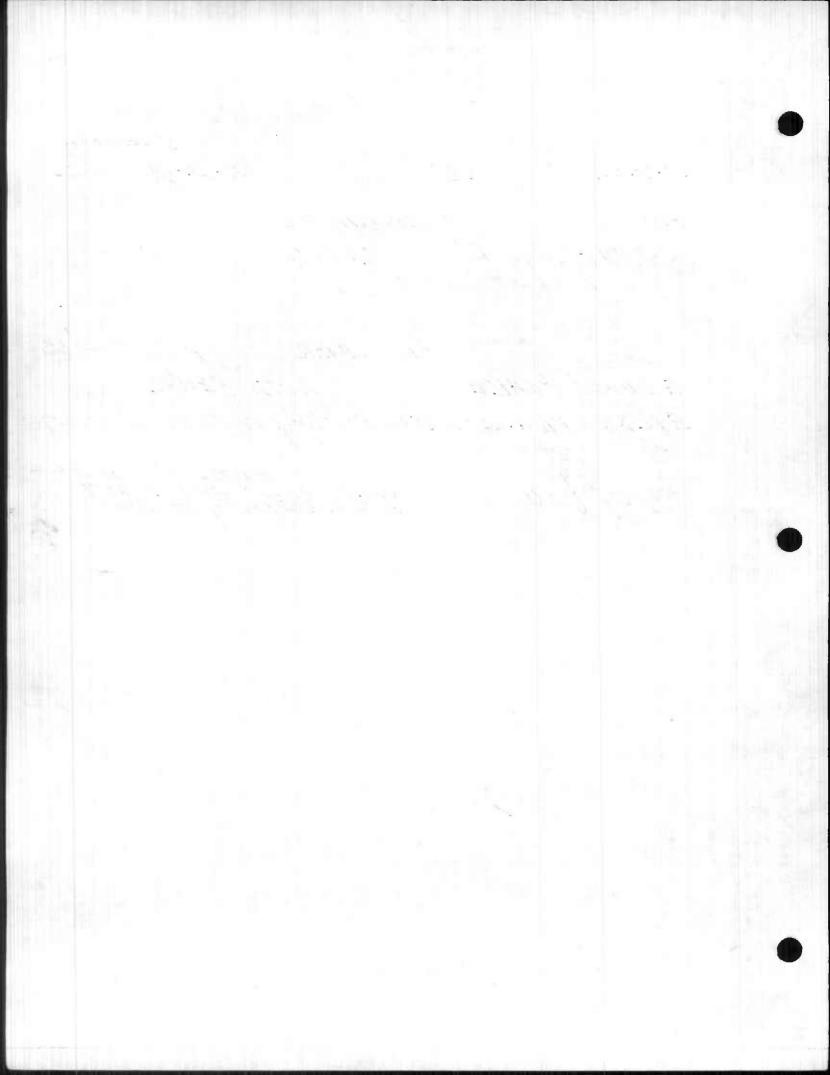
Northwest 32, Registrar'a Signature

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Center Randallstown, Maryland Hospita

28462

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Događeni's Name (First, Middle, Last) 2. Dete of Death 102 AM HOR: 2 **Physician** 1,2000 De /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE HOSPITAL City MARYLAND GENERAL 5. Social Security Number If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 213 94 9597 1□ M 21 F 3 Director Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show traumetic avent, the Medical Examiner must be notified at Ves 2□ No 141) BALTIMORE Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23s or CARCY Street 1220 21217 U.S.A. death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status permit. Pages 1 and 2 ahoutd be filed within 72 hours after of Department of Health and Mental Hygians. Important: If item 27 is marked other than "natural", or hem any injury or other traumatic avent, the Manner of Department of the Department of the Manner of the Ma 1 Never Married 2 Married 1□ Yes 22 No Specify: Specify: BIACK Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fit VOSS Receptionist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Costas FRANK PAGNE Shirley 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Point) Sister AUE 14 MAPLE KAREN Baltimone MARYLAND 21206 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 A Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 4-13-00 MITZION Cemetory 21. Separature of Funeral Service Licensee 22. Name end Address of Fecility JAMES A. MURTON & SONE FUNERAL HEAVE INC. 1701 Lourens Start Bactimus, Manyluns 81217 Elmes 23a. First Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner To the Nospital or Attanding Physician: The law requires that the death cartificate be executed within 24 bours after death. To the Funeral Director: After this cartificate has been signed by the attanding physician and completely filled in by the turnarial director, page 2 should be deteched for use as the burdar-transit completely filled in by the turnarial director, page 2 should be deteched for use as the burdar-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Due to (or es a consequence ol) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 D Onknown 1 Yes 2 No Division of Vitai Records, Ą 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 □ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 DiNatural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 2 Accident Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted. 29b. Signatore and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a 30. Name and address of person-(Type, Prir

State Registrar

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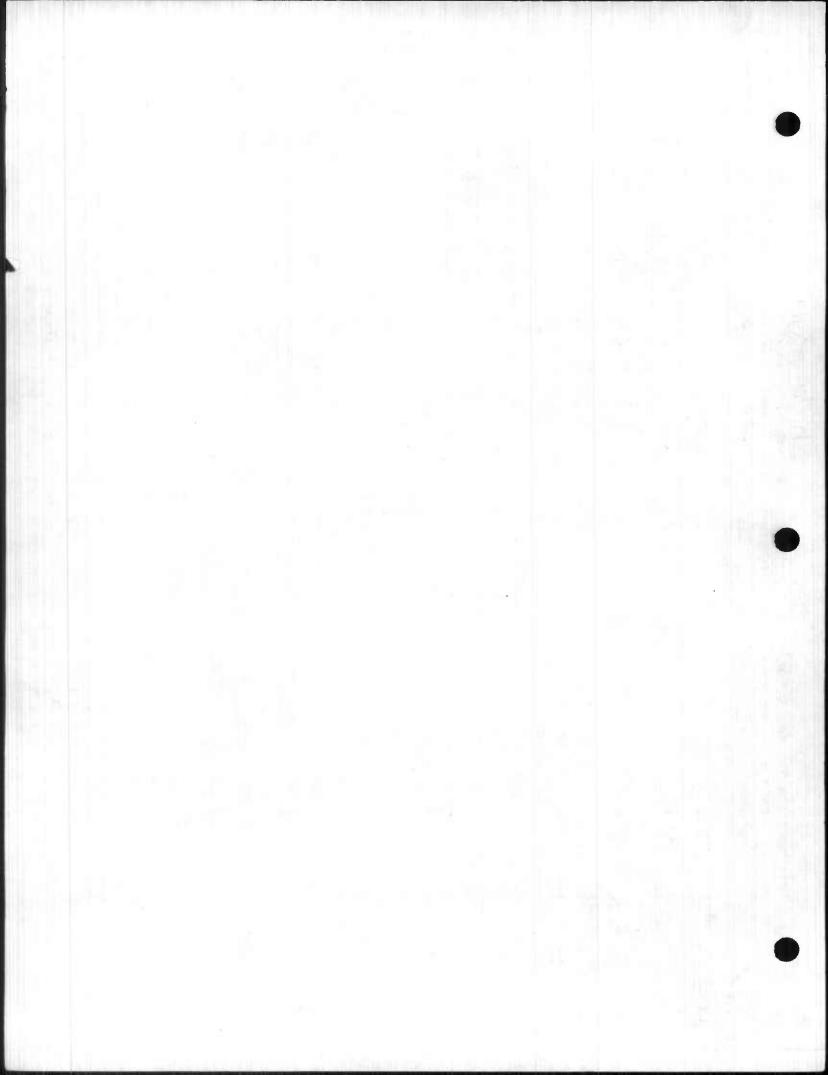
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ORIGINAL

32. Registrar's Signeture

0 2000



DHWH



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#8 perFHG782 4/11/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** ,2800 2 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Stown 0 If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 12/22/77 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1962 Months 62 1XM 20 F Yrs Director Usual Residence of Dacedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director New YORK 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Herns 23a Funeral deeth 12. Was Decedant Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merital Stetus Bleck. White, etc. filed within 72 hours aftar 1 Never Married 2 Merried 1 Yes 2 2 No altimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify. Aspecity: P 3 Widowed 4 Divorced Hmerican Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elamentery/Secondery (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnam Be Pages 1 and 2 should be of Health end Mental 2 19b. Mailing Addrass (Street and Number or Rugal Route Number, City or Town, Stata, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dete emetary, crematory or other place, 1 Burial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama end Address of Fecility 21. Signature of Funeral Service Licent oseph 212 Aue. a. Nor Th 23a. Pent. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hard failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final HEUTE FINTOXICATION LCGHGL diseasa or condition resulting in deeth) Examiner Due to (or es e consequence of) Physician/Medical Examiner The lew requires that the death certificate be asscuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the buria P.O. Box 68760, Due to (or es a consequence of): Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 6 3 Probably 4 Unknown Records, þ been signe should be d 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en autopsy performed? 2 🗆 No Division of Vital or Attanding Physician: 25. Was case referred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 7/60 1 Yas 2 No within 24 hours after death. Subject Ingested Alcohol investigation 2 Accident 3 Suicide in by 4 Homicide Hospital 29e. Certifier ş 29b. Signature end title of certified 29c. License number 29d. Date signed (Month, Day, Year) C.M.E. 30. Name and eddress of person who complated ceuse of death (Item 23a) (Type, Print)

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State

Registrar

PENN

STIERT, BALTIMONE, Maryland 21201

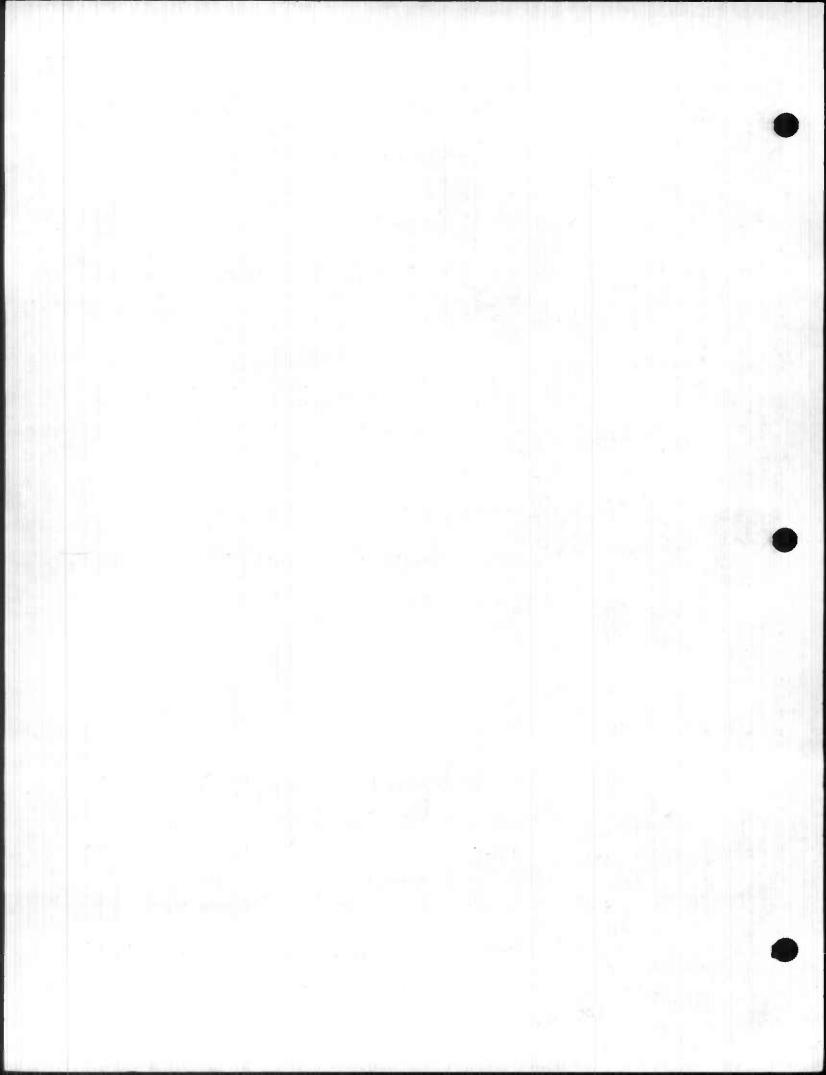
M.D

32. Registrar's Signeture

JACK M.

31. Dete filed (Month, Day, Year)

APR 10



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** APRIL 6, 2000 1941 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NIA AGNES HOSPITAL 900 CATON AVENUE BALTIMORE of If Under 24 Hrs. 6. Sex 1 M 2 □ F If Under 1 Yeer 9. Birthplace (State or Foreign N. Carolina 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 242-14-5043 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at NIA Paltimore 1 Yes 2 No MD Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 353 21229 filed within 72 hours after death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 1 Never Merried 2 Merried 1□Yes 2ENo Saltimore, Maryland 21215-0020 "natural", or Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assistant Nurse 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be ment of Health and Mental Ervin Smith Bertha Carron Department of Health and M Important. If New 27 is mark any Injury or other treumati poles. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Susan Edmondson-niece MD. alaay 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☑ Other (Specify) Kinston, North Carolina disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, failure. List only one cause on each line. 21. Signeture of Fyna al Service Lice Home P. Approximate Intervel Between Onset end Deeth **Physician** Immediate Couse (Final disease or condition resulting in death) /Medical Myocardial Infaretion nours Examiner Due to (or as e consequence of) by Physician/Medical Examiner Coronory distusc 10 YEARS The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Box 68760. Pulmonory Obotractive Due to (or es e consequence of): 5 months WHICH AR CETEBRU Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No ConceR 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en autopsy performed? Completed To the Hospital or Attending Physician.
Within 24 hours after death.
To the Funeral Director: After this certificate has for the Funeral director, page 2 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Certification: To Be 26. Place of Deeth (Check only one) 1□ Yes 2 No Hospital: Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Manner of Dee 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 28f. Localion (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

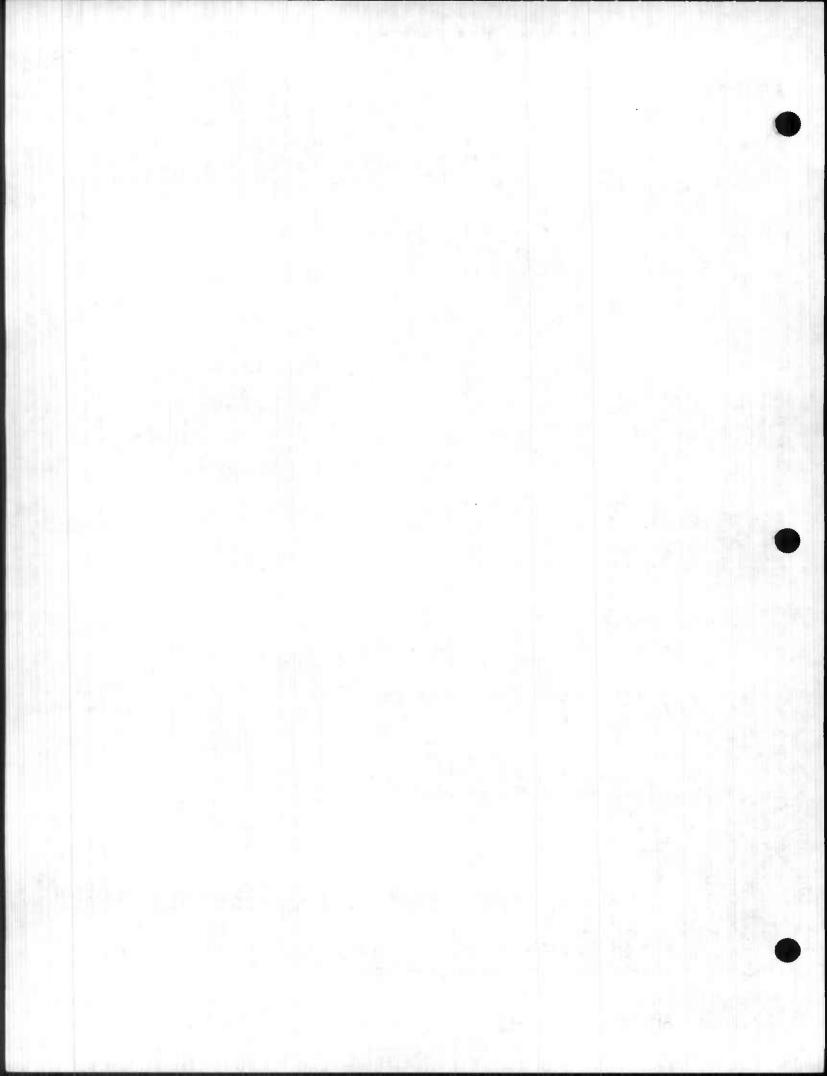
Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner steted. Medicai (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifles 29c. License number Frent >,mo HOUSE OFFICER Aeril 6, 2000 0 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Caton Bultimore, Morgland 21229 Doniel Frintlein, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

Nt

DHMH 16 Rav 6/95

Registrar

Marks



### Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** Edeltraud Schneider April 9, 2000 2 p.m. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 5624 Deer Park Road Baltimore Reisterstown If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. Year) | 9. Birthplace (Ste Country) | March 15, 1930 | Germany 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1 □ M 2 0 F Months 70 Yrs. 213-34-8893 Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Baltimore Reisterstown 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ĕ Examiner must be "netural", or thems 23s 5624 Deer Park Road U.S.A. 21136 Funeral 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus hours after 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ONO Specify. Specify: White ğ 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tited within Capartment of Health and Mental Hygiene Important: If hem 27 is marked other than "n any injury or other transmitted other than "n Elementery/Secondary (0-12) Cottege (1-4or 5+) Homemaker Housewife 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Patzak Hedwig 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1407 Woodridge Lane, Sykesville, Md. 21784 Wolfgang Schneider -Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Lake View Memorial Park Apr. 12,2000 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Examiner Due to (or es e consequenca of): Examiner CARDIOMYOPAThy attending physician and for use as the burial-transit certificata be executed Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequenca of): Box 68760. Hypertension Physician/Medicai resulting in death) Lest P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed The law has 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 27. Manner of Deeth 1 ☑Naturet 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After t s after death.
I Director: After to in by the funers 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. edicai 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of cartifier I Haber MD, uc 4-10-00 D24866

**DHMH 16 Rev 6/95** 

State Registrar

ZIO Business Center Dr. Reisterstown

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Graig G.

2000

31. Dete filed (Month, Day, Year)

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HABEL

MD

32. Registrer's Signature

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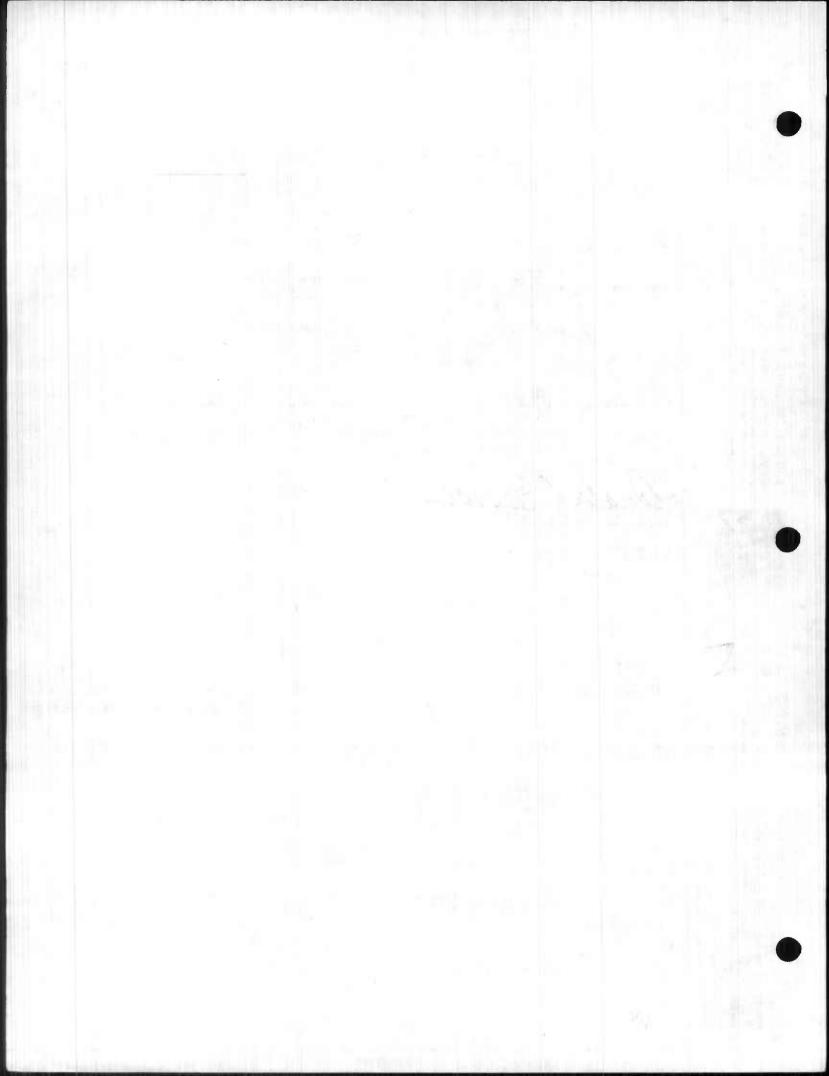
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Registrar

APR 1 0 2000

Schofield

Mildred



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** APRIL 1, HATTIE L. STATON 2000 5:50pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 3703 SPRINGDELL AVE. RANDALLSTOWN BALTIMORE If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 6 Sex 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1□ M 2以F Yrs Director 166-28-6649 68 NC 1-27-1932 Usual Residence of Deceden r 28a-f show notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. BALTIMORE RANDALLSTOWN Director 2 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 the Medical Examiner must be or Barne 23s 3703 SPRINGDELL AVE. 21133 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) -7--0-DISABLED N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be 2 should be 1 and Mental H is marked of WILLIAM G. STATON 2 ETTA DEBRULE 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important. If then 27 is m any injury or other traum BDSs. CAROLYN MANCE (DAUGHTER) 3703 SPRINGDELL AVE. RANDALLSTOWN, MARYLAND 21133 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriel 2 Gremation 3 Removal from Stete 4 Donatic Other (Specify) WOODLAWN CEMETERY 4-7-2000 BALTIMORE, MARYLAND 21. Signafi of Funerei Service Licenses 22. Name end Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical BREAST CANCER 8 YEARS Examiner Due to (or es a consequence of) Examiner siclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) certificate be exec the attending physician thed for use as the buria Box 68760 Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, by 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Pesidence 6 Other (Specify) 10 this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After ! al or Attending P after death. I Director: After 5 Pending investigation 1 Neturat 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture and titla of certifies 29c. License number 29d. Date signed (Month, Day, Year) D29071 APRIL 7, 2000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

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2000

31. Dete filed (Month, Day, Year)

APR

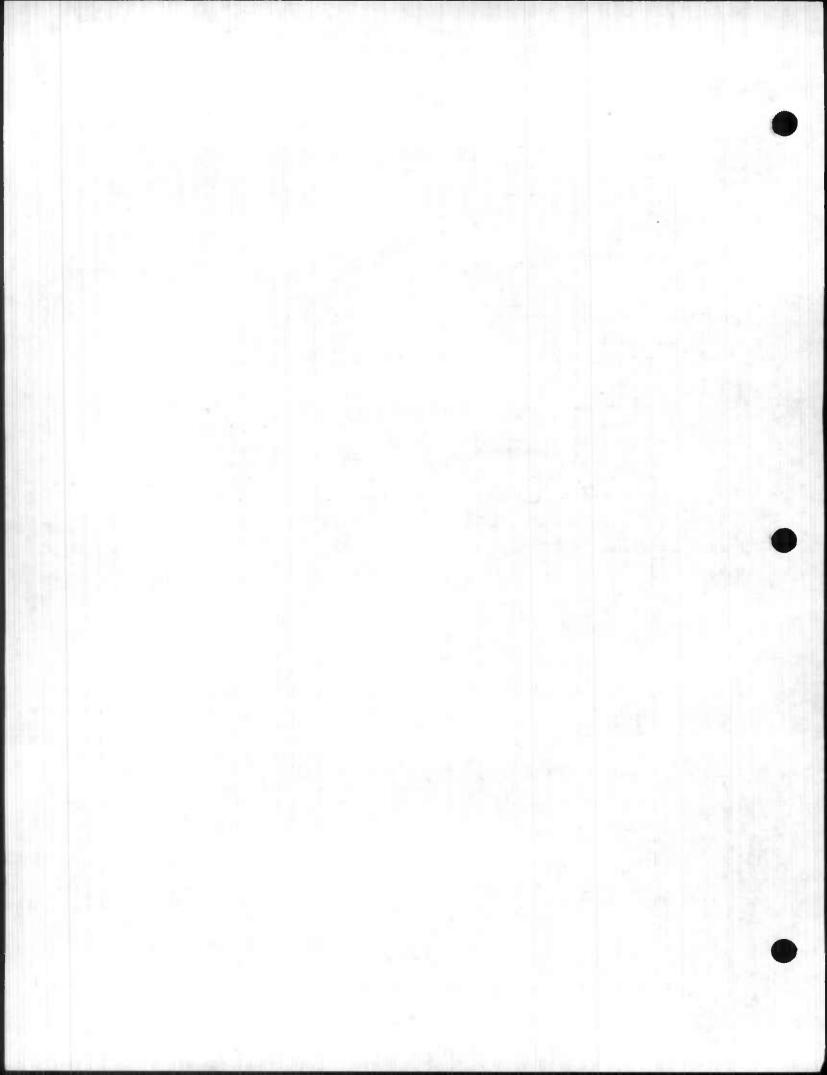
**DHMH 16 Rev 6/95** 

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821 N. EUTAN

32. Registrer's Signeture

ST \$ 305 BALTIMORE MO 21201



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** 35 ROLAND L. SMITH PRI 2000 /Medical 4b, City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner STELLA MARIS AT MERCY HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) MD . 7. Age (In yrs. last birthday) 6 Sev 8. Dete of Birth (Month, Day, Year) **Funeral** Montha Deys Hours 1♥ M 2□ F 213-32-6702 63 Yrs. Director 9-22-1936 Usual Residence of Decedent 10n State 10d. Inside City Limits 10b. County 10c. City, Town or Location show rst', or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA Funeral 2813 BRIGHTON 21216 e. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygieno. nr. If Itam 27 is marked other than "natural", or iter mry or other traumale event, the worder traumale event, the worder. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be 2 HERBERT SMITH ELIZABETH SMITH 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2813 BRIGHTON ST. BALTIMORE, MARYLAND 21216 SHIRLEY M. SMITH(WIFE) 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Department of Himportant: If its any injury or ot 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State METRO CREMATORY 4-7-2000 BALTIMORE, MARYLAND 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, bck, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es a consequence of). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieled events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of) been signed by the a should be deteched t Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? page 2 has 1 Yes 2 No 1 Yes 20 No certificate 25. Wes cese referred to medicel examiner? 26. Place of Deeth (Check only one) STELLA MARIS AT MERCY Other: 4 Nursing Home 5 Residence 6 Mother (Specify) # 0 S Dic Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Meryner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? After Natural 5 Pending investigation 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 29e, Certifier 12 certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. (Check only one) pletely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 To the the th 29b. Signature and title of certifier 29d. Dete signed (Month, Dev. Year)

State Registrar

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DAVID KISE 31. Dete tiled (Month, Day, Year)

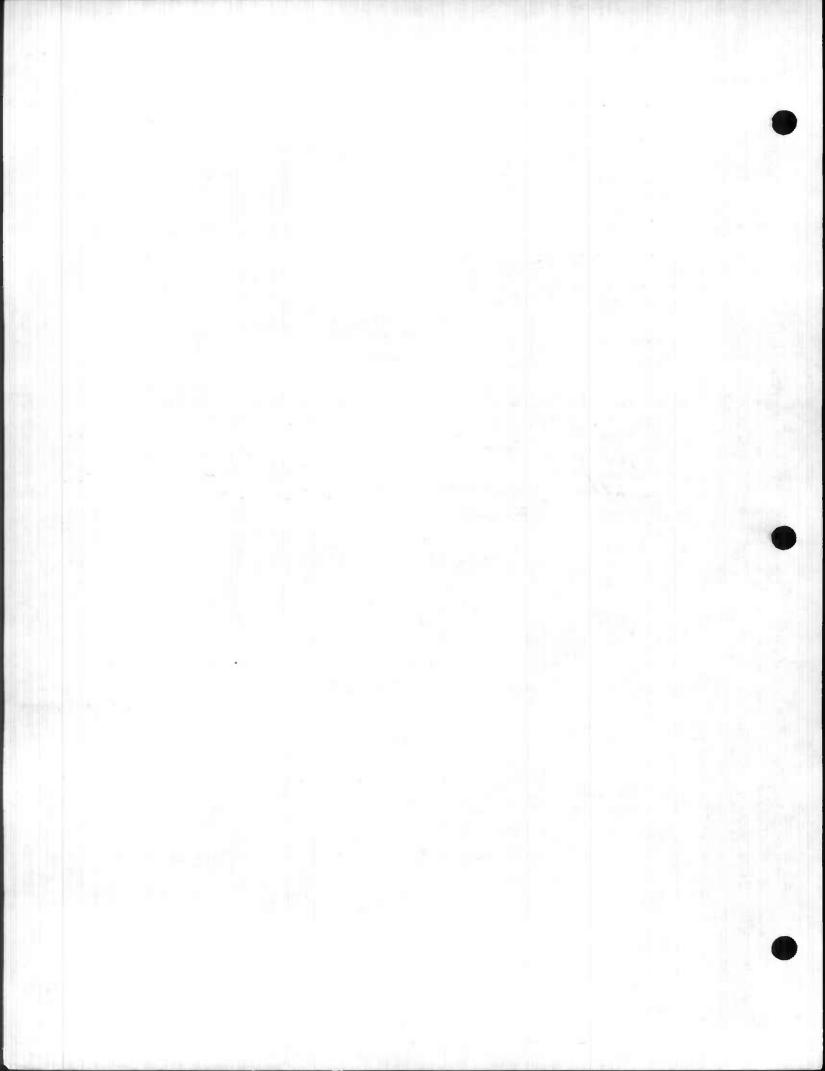
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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signeture

DHMH 16 Rev 6/95

BALLIMORE

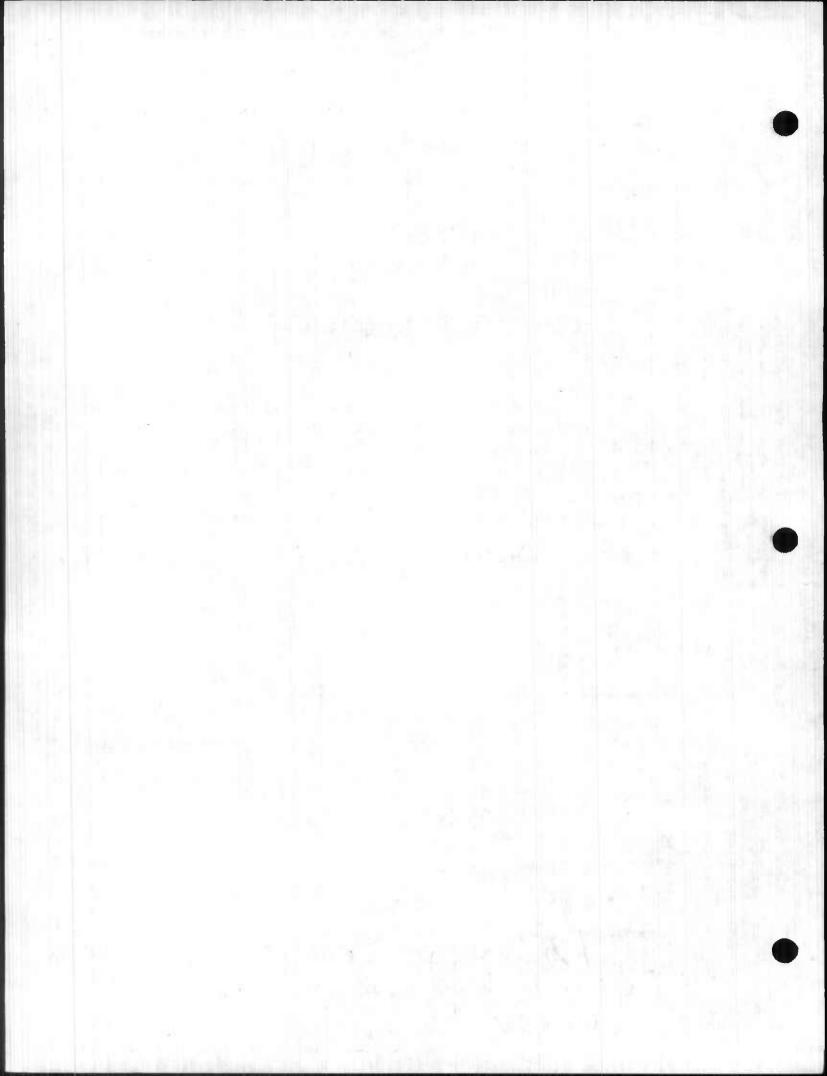


### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Maryland / Department of Health and Me  Certificate of Death		ene (	0 11	1561
120			1. Decedent's Name (First, Middle, Last)	. Date of Death Month	Day	year 3. Ti	ime of Death
	/M	rsician ledical aminer	Hilda Sanders AA 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loca	RIL Z	4c. County	2000	17:39
	MIL		St. Agnes Hospital Baltimore	9			4000
837	Fune	· ·	Months Days Hours Min.	. Date of Birth (Month, Day, )	rear)	9. Birthplace (S Country)	
	Direc	tor	213-16-6854 87 III.	10 12	12	M.D.	p
	anylen		10a. State 10b. County 10c. City, Town or Location				Side City Limits
	th with the Maryler 23s or 28s-f show	Director	MD NA Baltimore  10e. Street and Number 10f. Zip Code	100	g. Citizen of W		Yes 2□No
	with year	ioi	4114 Rokeby Road 21229	101		S.A.	
	ler dee	by Fune	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Richard Forces) 1 Yes 2 No Specify: 1 Yes 2 No Specify:	ty Yes or No- can, etc.)	14. Race	e - American Indi k, White, etc.	
	21215-0020 within 72 hours ef	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16	6b. Kind of Bu	siness/Industry	144
	121 led wi hygien her th	Con	12th grade na Teacher's Aide	5	Scho	-	
	and the fill	Be	17. Fether's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19. Mother's Name (First, Middle, Last)  19. Mother's Name (First, Middle, Last)		uden Sumam	Θ)	
	Maryland 212- nd 2 should be filed within Ith and Mental Hygiene.	To	George W. Jackson  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural F		City or Town,	State, Zip Code)	)
	Md 2		Ethel Hunter-Sister 1606 St. Stephens St	t. Bal	timore	e Md a	21216
	0 % 0 =	ano so		Date 20	oc. Location -	City or Town, Sta	ate
	Baltim pemit. Pag Depertment Important: 1	and	4 Donation 5 Other (Specify) Arbutus Mem. Park 4-6	5-00 A	rbutua	s, Md	
	Balt permit. Depend	DUCE	March F/H West				
	-		23a. Part1. Enter the disease, or complications that caused the lath. Do not enter the mode of dying, such as cardiac or r			Appro	oximate
1,1da	Physics /Medi Examin	cal	Immediate Cause (Final disease or condition resulting in death)  Let Compare the constraint of the con				val Between it end Death
7	D 4	ne ne	Due to (of as a consequence of).			1	
Sanders	Box 68760, leath certificete be executed attending physician end		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
S	Box ath cert	by Physician/Medi	d				
	O. Figure 1	ysici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tob	acco use cor	ntribute to the c	ause of death?
LC T	Is, P.O. es that the de igned by the s	y Ph		1 Yes 2 No 3 Probably 4 Unknow			4 Unknown
	ecord ew requir	pleted		24a. Was an perform		24b. Were aut aveilable completic of death?	topsy findings prior to on of cause
	E off .	Cod		1 ☐ Yes	2 No	1 🗆 Yes	2□ No
-	f Vital Inysician: The is contificate	Be	25. Was case referred to medical examiner?  Hospital: Other: Other:			40. 71	
	Phys		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	e 5 ☐ Residen d. Describe hov			77.2
	Sion o tending Ph leath. to: After th	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No				
	Division Hospital or Attending 24 hours after death. Perserial Director: After	Sertific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stre City or Town,	et and Numb State)	er or Rural Route	e Number,
	Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After Af	edical Certification:	29a. Certifier (Check only one)  10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cat at the time, dat	ise(s) and ma le and place, :	inner as stated. and due to the ci	ause(s)
	To the To the	2	29c. Signature and this of certifier 29c. License number 0 27 3 1 5	29	Date signed	d (Month, Day, Y	
	M	+	30. Name and address of person who/completed cause of death (Item 28a) (Type, Print)  ML Frydlub Ord St. Aynes H	ospit	-u 1	1	
		State	31. Dele filed (Month, Day, Year) 32. Registrer's Signature	ADAIA	al		
	Reg	jistrar	APR 1 0 2000 Show & Sports				

DHMH 16 Rev 6/95

ORIGINAL



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Year Smith Don 4b. City, Town, or Location of Death 5:20 AM Henry Smith /Medical ZOOU 4a Eacility Name (If not institution, give street end number) 4c. County of Death Examiner Hospita Belveder 2401 Baltimore If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 11 29 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Days Hours MM 2□F Yrs Director 89 D.C. 218-05-3747 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits 1 X Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23a 5430 Park Heights ts Ave Apt 4 12. Was Decedent Ever in U.S. Armed Forces? Funeral 423 21215 U.S.A. 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 Nevar Married Married 1 Yes 2 2 No "natural", or 1 ☐ Yes 2000 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than any filury or other traumatic event, the Medica. Elamentary/Secondary (0-12) Collega (1-4or 5+) 10th grade Sanitation Worker Baltimore City Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Unknown Helen Landon 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5430 Park Height Ave, Apt 423 Baltimore Lula Smith-Wife 20b. Place of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Dispo Date 20c. Location - City or Town, State 1 Durial Cremation 3 Removal from State 4 Donal Other (Specify) 4-11-00 Randallstown, Md King Memorial Park 21. Signatura of Fu IIII Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it fallura. List only one cause on each line: Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical 55:7 Examiner Due to (or as a consequence of): Examiner ettending physician and for use es the burial-transit be executed Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by been si 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s certificate 1 Yes 202No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 hpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Panding after death. 2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, straet, fectory, office building, etc. (Specify) 4 ☐ Homicide ò filled in 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edica 29a. Certifier completely (Check only onel within 2 the th 2 and pulse of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Ray 6/95

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31. Date filed (Month, Dey, Year)

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32. Registrar's Signeture

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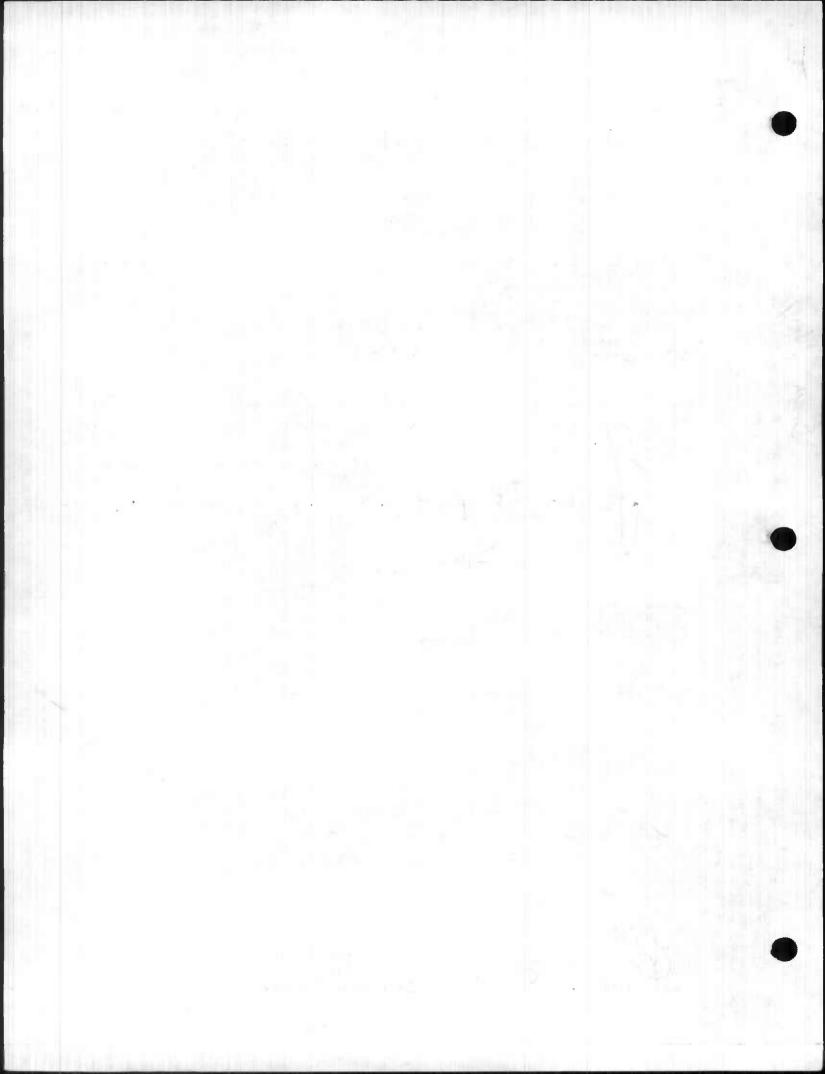
address of person who completed cause of death (Item 23a) (Type, Print)

& Sporks

2000

ORIGINAL

2401



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#6 PER F.H. G782 4-11-2000 JAB Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year THOMAS BERNITTA APRIL 4th 10:15 am 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA HOSPITAL Baltimore SamARITAN 8. Date of Birth (Month, Day, Year) ALPRIL 30, 1927 If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Hours 1□ M 2⊠ F 220-22-6263 77 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43rd Street United States 520 East 21212 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Marriad 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 Yes 2 No Specify: specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), Vurse (+59:5+art) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Home Elementary/Secondary (0-12) College (1-4or 5+) Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) -illian Malichi Merritt 19a, Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43rd St. Balto, MO 21212 520 East Roslyn Johnson - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete Burial 2 Cramation 3 Removal from Stata ison Forest VACem 4/10/00 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Smith & Will 2-8 18 East 21. Signature of Funaral Service Licansee Funeral Home, P.M. mith te Bullo, MD East Bobtimer Approximete Interval Between Onset and Death 23a. Part. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Causa (Final ACUTE MYOCARDIAL INFARCTION disaase or condition resulting in death) DISEASE ONONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown COACULOPATHY, ACUTE LIVER 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? PULMONARY MYPERTENSION 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner 68760. P.O. Box Records, Be Completed by certificate Division of Vital To the Hospital or Attending Physician: edical Certification: To filled in by the funeral After within 24 hours after death. To the Funeral Director: A

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or 28a-f ahow

238

Reme :

permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or he any injury or other traumatic event.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

py

Be Completed

1 Yes 2 No 27. Manner of Death 1 Deturel
2 Accident 3 Suicide

4 Homicide

29a. Certifier

25. Wes case referred to medical

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and fitte of cartifier

31. Date filed (Month, Day, Year)

SAMARITAN

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

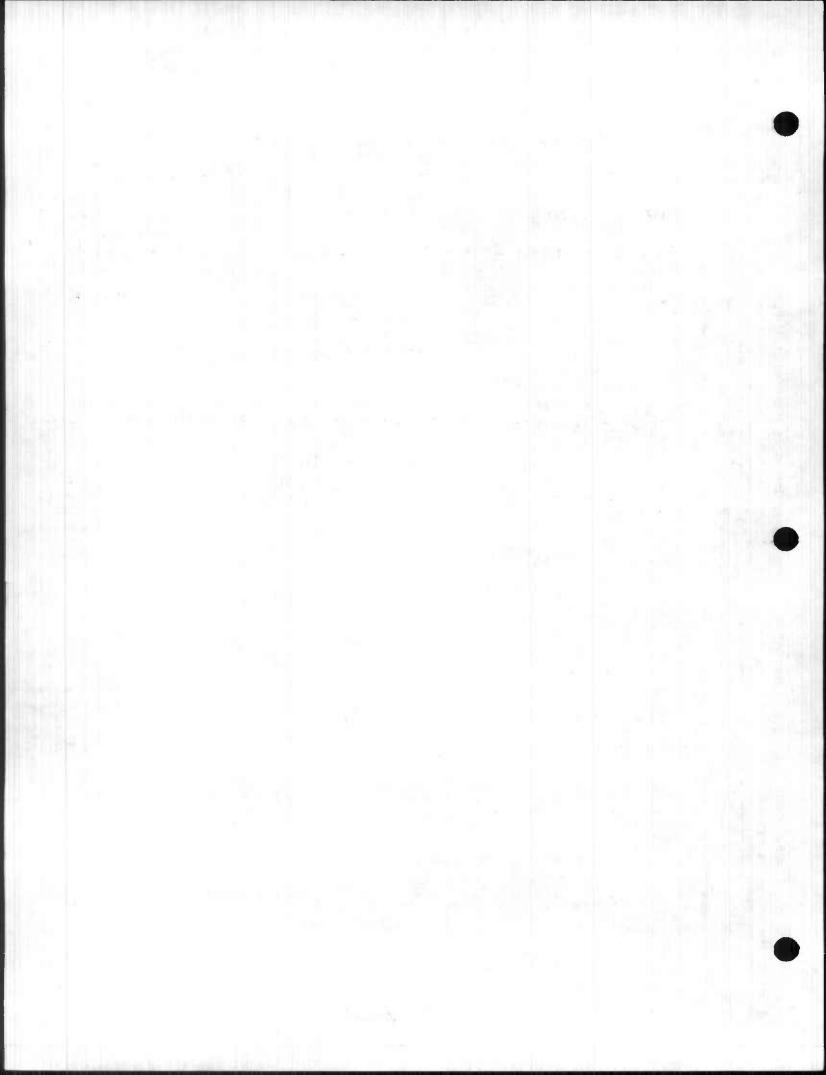
SECT LOCH RAVEN BOULEVARD

ELIZABETH 6000 MOSPITAL BAITIMONE MD

State Registrar

32. Registrar's Signature

DHMH 16 Rev 6/95



### Please Type or Print in Black indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Ting of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John J. Tyska 7, 2000 8.15pm April 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 99 215-09-0980 August 8,1900 Maryland Usual Residence of Decedent 10e State 10h Counh 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 HNo Maryland Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 United States 12. Was Decedent Ever in U,S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Conveyor Operator Railroad 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tvska Roman Minnie Krupniski 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3620 Langrehr Road George Martin/Brother-in-law Baltimore, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State VORBurial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 4/10/00 Woodlawn, Maryland 21. Signatur of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. Homas 4107 Wilkens Avenue uanita Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I, 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 145 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death cartificate be executed P.O. Box 68760. Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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Completed

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Examiner

Physician/Medical

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**Physician** 

/Medical

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Baitimore, Maryland 21215-0020

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To the Hospital or A within 24 hours after 7 to the Funeral Director completely filled in b.

State Registrar

A no rew 31. Date filed (Month, Day, Year) APR 1 0

29e. Certifier

(Check only one)

29b. Signature and title of confident

30. Name and address of partion who completed cause of death (Item 23a) (Type, Print) (921,5 115 32. Registrar's Signature Uper

Maiden

Choice Dacks

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

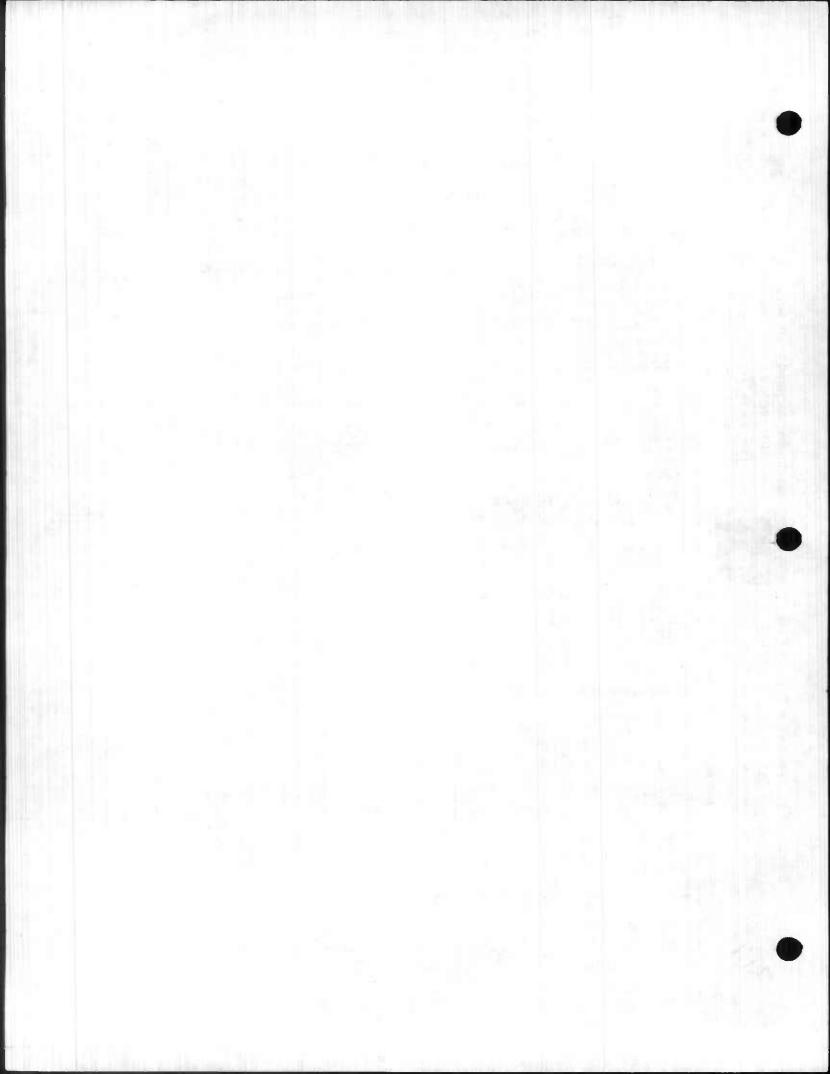
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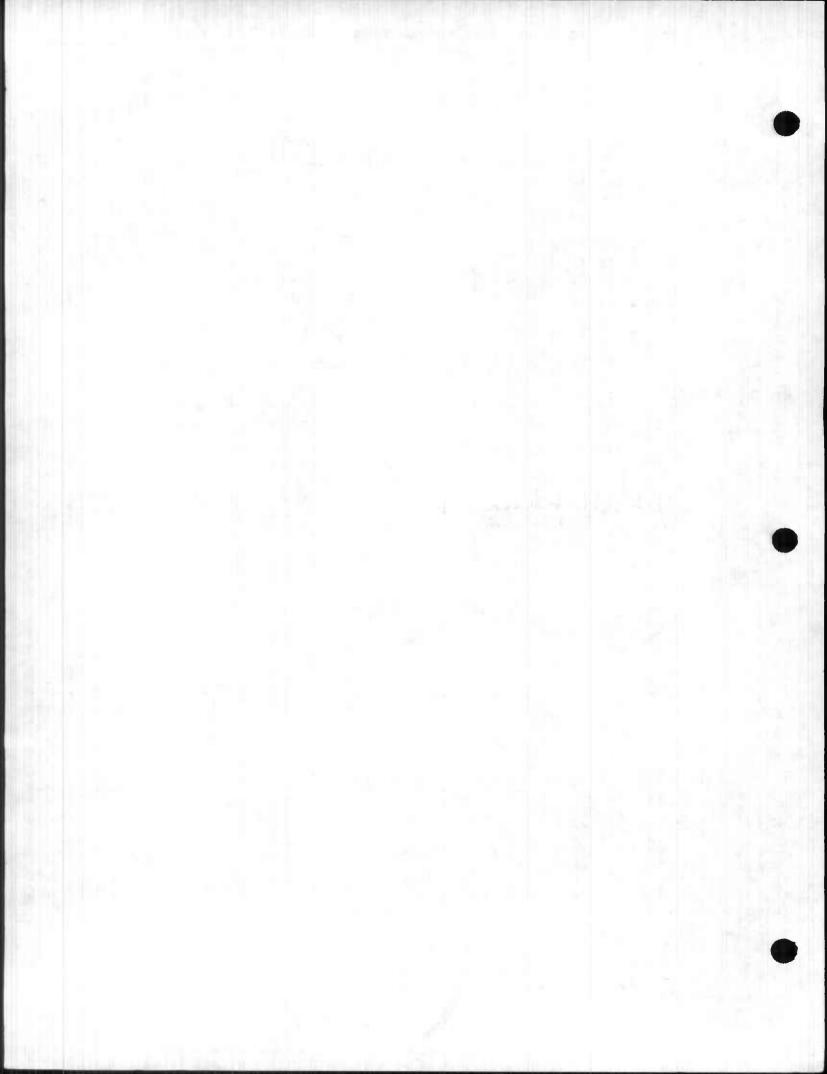
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THEN Lake, MD 111 Penn Street, Baltimore, Maryland 21201		/ atriens		0.	C.M.E.		APRIL	7, 200	0	
	7	30. Name and address of person who completed cause of deeth (It	em 23e) (Type,		reet, Ba	timore	, Marvla	nd 212	201	
State 31. Date filed (Month, Day, Year) 32. Registrer's Signeture 4 Apr 1 0 2000	State			/			2			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death **Physician** Month Day Marvin Willis Jr. 5:15pm April 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth **Examiner** 335 Stone Castle Ave. Reisterstown Baltimore Months Days Hours Min. Apr. 22, 1942 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) Birthplaca (State or Foreign Country) **Funeral** 1 M 2□ F 220-36-7779 57 Yrs Director Kentucky Usual Rasidance of Decedant death with the Maryland 10e. Stete 10b Count 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Md. Baltimore Reisterstown 1 Yas 2 No Director 10f. Zip Coda 10e. Street and Numbar 10g. Citizan of What Country? ò 335 Stone Castle Ave. 21136 USA Items 23a Funerai 12. Wes Decedant Evar In U,S. Armed Forcas? 1 May 2 □ No If Yas, Giva Yeer or Detas: 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after or nent of Heelth and Mental Hygiene. nnt: If Item 27 is marked other than "natural", or item 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) MIllwritht Steel 12 yrs.
17. Fether's Nama (First, Middla, Last) 12 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Marvin Willis Sr. Anna Bentley 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Department of Heelth at Important: If Item 27 is any injury or other training. Sandra J. Willis wife 335 Stone Castle Ave.Reistertown Md. 21136 Baltimore, Data 10 20a. Mathod of Disposition 20b. Pleca of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ■ Buriel 2 □ Cramation 3 □ Ramovel from Stata 4 □ Donation 5 □ Othar (Specify) Apr Oaklawn Cemetery 2000 Dundalk, Md. 21. Signatore of Funaral Sarvica Licenses 22. Name and Addrass of Facility
Connelly Funeral Home of Dundalk, P.A. onnelle 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Part I Enter the disease, or complications thet caused the deeth. Do tot antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner 1.5 The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last and 9 Box 68760. physician 9 Physician/Medicai the Dua to (or as a consequance of) USB ed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 □ Yss 20 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara eutopsy findings evailable prior to completion of causa of deeth? Completed 24a. Wes en autopsy parformed? has this certificate 1 ☐ Yas 2 📉 No 1 ☐ Yes 2 No Attanding Physician: 25. Was casa refarred to medical axaminar? Be 28. Placa of Deeth (Check only one) Hospital: Othar: 4 ☐ Nursing Home 5 🕅 Residance 6 ☐ Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpetiant 3 DOA funerai 27. Menner of Deeth 28e. Deta of Injury (Month, Dey Yaer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending invastigation 1 Yes 2 No death i or Attand after death Director: A 2 Accidant To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 6 Could not be 3 Suicida 28a. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 4 Homicide 12 Cartifying Phyeician: To tha best of my knowladge, deeth occurred at tha time, dete end piece, end due to the ceuse(s) end menner es steted. 29e. Certifier Medicai 2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, deeth occurred at the time, dete and place, end due to the causa(s) and menner steted. 29b. Signature 29c. Licanse number 29d. Data signad (Month, Day, Year) 06

State Registrar

31. Dain filed (Month, Day, Year) 2000

32. Registrar's Signatura

ass of person who complated causa of daath (Itam 23a) (Type, Print)

Sparks

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#8 PER F.H. G782 4-13-200 JAB Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dele of Deeth ARIL Helen Barbara Walker 11:30 AM 05 2000 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Union Memorial Hospital If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth ( 3 37 9. Birthplece (Stete or Foreign Deys Hours 1□M 2□F 63 Yrs. 214-20-3545 MD Usuel Residence of Decedent 10a. Siele 10b. County 10c. City, Town or Location 10d. Inalde City Limits XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of Whet Country? 21213 USA 2135 E. Chase Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16s. Decedeni's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mercy Villa 12th Grade Cook 17. Felher's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mamie William Speller 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21213 19e. Informent's Neme/Reletionship (Type, Print) 2135 E. Chase Street Baltimore, Maryland Walker 20b. Pleca of Disposition (Neme of 20c. Location - City or Town, Stele 20e Method of Disposition 1 Burial 2x Cremelion 3 Removel from State 04-011-2000 Baltimore, MD Greenmount Cemetery 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Baltimore, Maryland 21202 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Bla WM.C.March FH 1101 E. North Avenue Approximate Intervel Between Onsel end Death Immediate Cause (Final disease or condition resulting in death) Asbiration meumoma 2 Weeks 2 weeks Hyponatre ma Due to (or es a consequenca of): 2 weeks Grandmal Suzure Due to (or es e consequenca of) 2 weeks Encephalopathi Pert II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert I.

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

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After t

after death.

To the Hospital e within 24 hours a To the Funeral D

filled in by

P.O. Box 68760,

of Vital Records,

Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Department of Health a Important: If Item 27 is any injury or other trate page.

filed within 72 hours after

Pages 1 and 2 should be

Maryjand 21215-0020

Baitimore,

the Medical Examiner must be notified at

Director

Funeral

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Completed

Physician/Medical Examiner

Medical Certification: To Be Completed by the funeral

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initialed events resulting in death) Last

Hospitel: 1 □ Impalient 2 □ ER/Oulpalient 3 □ DOA

28e. Plece of Injury - Al home, farm, street, fectory, office building, etc. (Specify)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown

24e. Wes en eutopsy performed? 1 Yes 2 MNo

24b. Were autopsy findings evailable prior to completion of cause of deeth? 1 ☐ Yes 25 No

26. Plece of Deeth (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury el Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and menner stelled. 29b. Signeture end title of certifier

dovem

25. Wes case referred to medical

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Mannes of Death

1 PNelurel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number AT 2438946 29d. Date signed (Month, Dey, Year) April 05, 2000

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

PUTHUMANA, UNION MEMORIAL HOSPITAL BALTIMORE, MD LOVEENJ 31. Dele filed (Month, Day, Year)

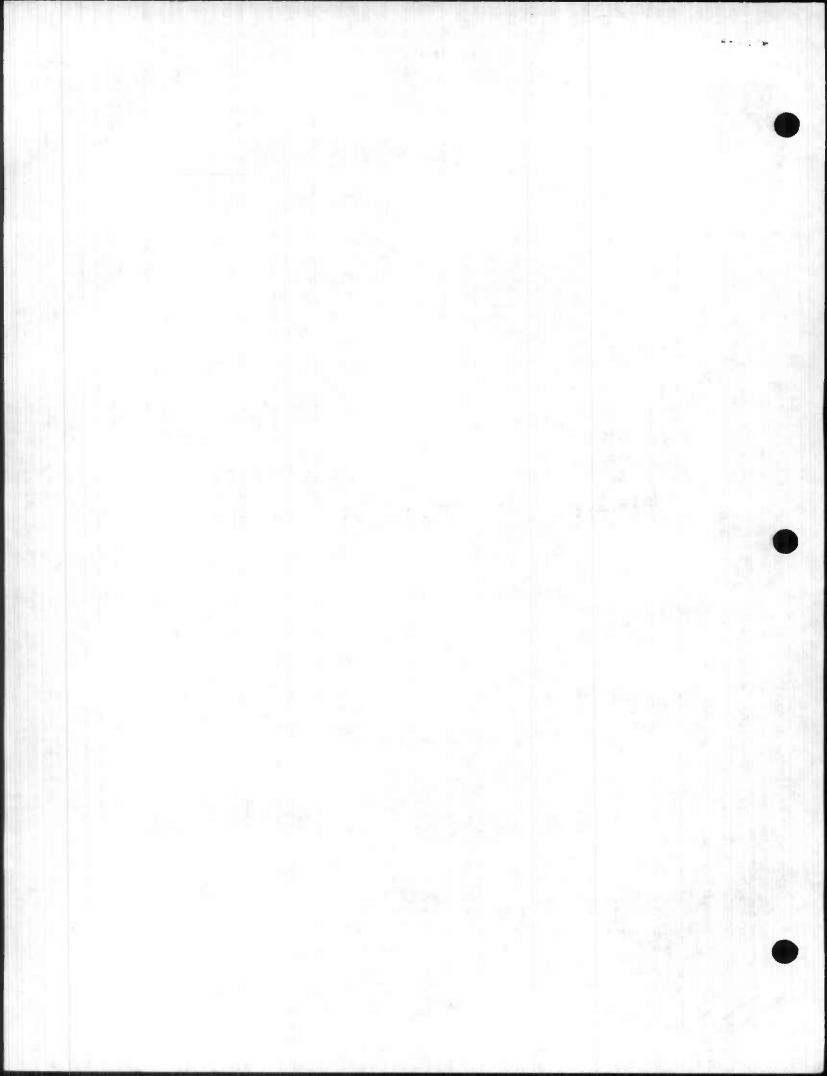
State Registrar

APR 1 0



Puthinana, M. D

28a. Dete of Injury (Month, Dey Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** MAJOR WILCON APRIL 2:36 PM 05 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Pracrimores HOSPITAL 4000 MATISTAMENT If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours ₩ 20 F 214-26-7419 67 Director 04-20-32 MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahoa XX Yes 2 No Director MD NA Baltimore or harns 23a or 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1508 Kingsway USA 21218 Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? X⊠Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. ther then College (1-4or 5+) NA Elementery/Secondery (0-12) High Sch. Grad Pompeian Olive Manager Oil Company 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) Be h and Mental I Pages 1 and 2 should be Major Wilson, Clara Bell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 21218 19e. Informent's Neme/Reletionship (Type, Print) Cepartment of Health as Important: If them 27 is a Saverne Wilson 1508 Kingsway Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta X Burial 2 Cremation 3 Removel from Stete Garrison Forest VA Cem. 04-11-2000 Owings Mills 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feiture. List only one cause on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediete Cause (Finel PNEUMONIA PNEUMOCUCCAL 1 DAY. disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): 68760 Physician/Medical Dua to (or as a consequence of): Box ( P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown RENAL CARCINOMA signed i Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s 1 ☐ Yes 20 No 1 Yes 2 PNO Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Wes case rafarred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No to Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural Accident 5 Pending 1 TYes 2 No investigetion 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicida 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 [] Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. ş 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-12562 tradio APRIL OS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARISAN HOM, BAITMINE MAINMARA

OBI

32. Registrar's Signature

31. Date filed (Month, Dey, Year)

2000

APR 1 0

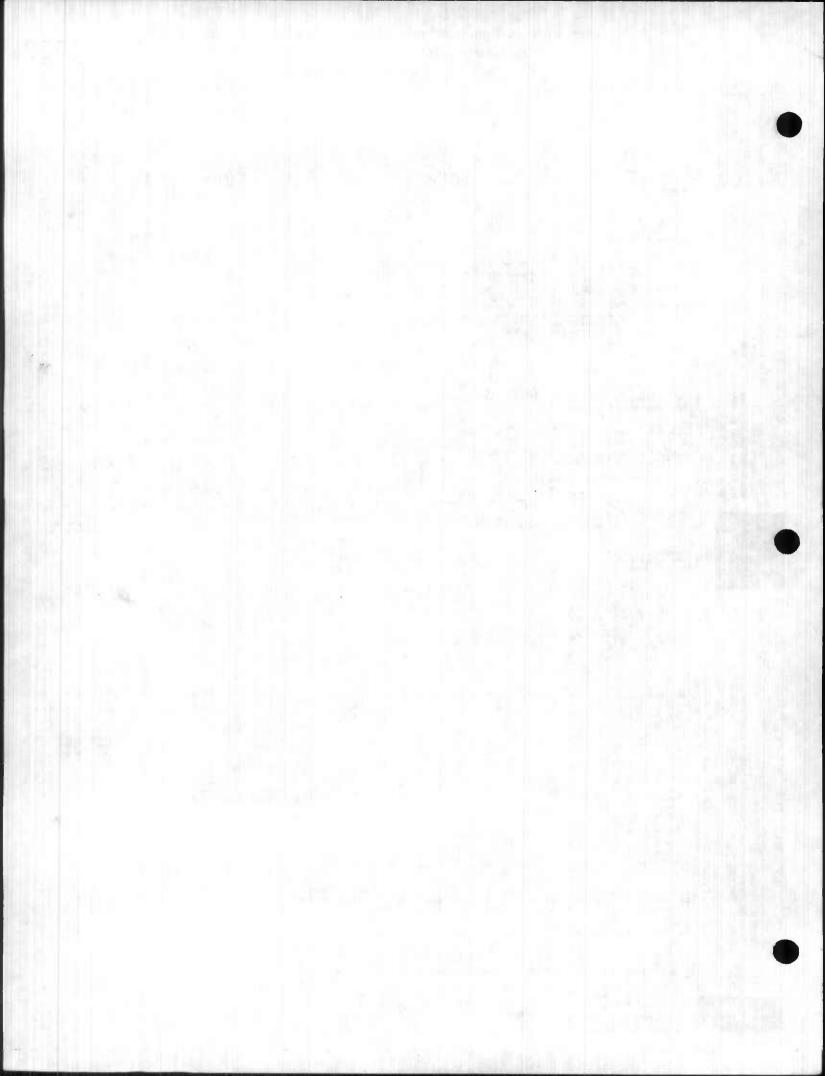
Registrar

ORIGINAL

### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 11569

					Ce	rtificate o	f Death	Re	g, No.		
	Dhusisia	_	1. Decedent's Nama (First, Middle, Las	(1)	V			2. Data of Death		3. Tima of Death	
4	Physicia /Medica	_	Ourpara	E. Whi	te			APRIL	02 200		
	Examine		4e Fecility Neme (If not institution, give	street and number)			4b. City, Town, or I	Location of Death	4c. County of I	Death	
			GREATER BALTIMO		NTER	I II Index 1 Vo	TOWSON		BALTI		
	Funeral Director	4	5. Social Security Number  218-76-1678  Usual Residence of Decedent	T. Age (In yrs	last birthdey)	Months De		8. Date of Birth (Month, Dey, JUNC /	Year) 9.	Birthplaca (State or Foraign Country)	
	fand	-	10a. Stete 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
	the Mary 28a-f ah	Director	M)  10e. Street and Number	IA	Bi	ALTIMU 101. Zip Cod	, -	110	og. Citizen of Wha	1 ☐ Yes 2 □ No	
			1217 W. Mu	12. Was Decedent Ever in I	+.		2/2/1	7	US	5A American Indien,	
215-0020	urs after	by Funeral	11. Marital Status  1 Nevar Merried 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 27 No If Yes, Give Yeer or Dates:		If Yas, specify C	of Hispanic Orlgin? (Suben, Mexican, Puart	o Rican, etc.)		Whita, etc.	
2-0	72 ho	S -	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usuel Oc	cupation	tkina	16b. Kind of Busin	ess/Industry	
2121	within ene.	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use ret	ne during most of wor ired) U	/	Halth	Provider	
pu		Be	17. Fathar's Neme (First, Middle, Last)	12. · L			18. Mother's Nar	ne (First, Middle, A	feiden Sumema)		
yla	D 8 3 0	2	Joseph M.	White			alpi	here	White	/	
Mar	2 sh and is m		19a. Informant's Neme/Reletionship (7	1	19b. Melli	ing Address (Stre	eet end Number or Ru	iral Route Number,	City or Town, Sta	ite, Zip Code) 4 FT. 602	
e,	Health Fire 27 ther t	-	20e. Method of Disposition	e mother	Place of Dispo	osition (Nema of	. Frank	Date 1	Oalt mor	RIMID 21201	
altimor	artment of injury or or		1  Burlel 2  □ Cremetion 3  □ 4  □ Donetion 5  □ Other (Specify	Removel from State		ZIDN C	enetry	4/7/00	1	oune, MD	
Ball	Departm Importar any injur		21. Signatura of Funarel Service Licen	2	2	2 Name and Ad	dress of Facility	eral 1			
	Dhusisian	1	23a. Pert1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,    Approximate   Interval Between   Interval Between								
ı	Physician /Medical Examiner										
	D &	ner		AID Due to	or as a conse	quenca of):				y	
,	be executed sician and burial-transit	Examine	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury	Due to (or es e consequence of):							
09289		edical	thet initieted events	C. Dua to (	Dua to (or as a consequence of):						
	\$ 0 a	-	resulting in death) Last	d. Outs CVB 2 Seeyer					Jules	1-2 deg	
Box	death cer		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of death?			
, P.O.	d by th	L L	Pert II. Other significant conditions of	ntributing to death but not re	thottesuling in the underlying cause given in Pert I.				1 Yss 2 No 3 Probably 4 Hhknown		
ords	law requires thet es been signed t	Completed by			44			24a. Wes a perform		24b. Were eutopsy findings available prior to completion of cause of deeth?	
R	The law ate hes page 2	E						1 □ Ye	s 2 HV6	1 Yas 2 No	
ita	certificate		25. Was case referred to medical examinar?				26. Plece of Dec	eth (Check only on	9)		
of <	Physician: this certific ral director,	0	1 Yas 2 No		☐ ER/Outpatie	nt 3LI DOA		fome 5 🗆 Reside	nca 6 Other (	(Specify)	
2	Attending Pi r death. ector: After th by the funera		27. Mannar of Death  1 Netural 5 Pending 2 Accident Investigation	n (Month, Day Year) tnjury Work? 1 □ Yes 2 □ No					28d. Describe how injury occurred		
	is after death at Director: / ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ HomIcide determined	28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)  28f. Location (Street end Number or Rural Route Number, City or Town, Stete)						or Rural Route Number,	
		edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end manner as stated.  2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.								
	vithin Nompl	100	29b. Signature and title of certifier	7	Here	29c. Lice	ense number	2	d. Date signed (A	Month, Day, Year)	
	01	/	► Whelin E	Carlelda	phy sic	a I	15808		4/41	w	
	il.		30. Nema and address of person who c	completed cause of deeth (Ite	m 23a) (Type,	Drint) St.	20 33			ERULLE	
	MA		WILLIAM E		- / -	nn 1:	205 Yul	uc Ri	ma	21093	
	State	9	31. Data filed (Month, Day, Year)	32. Registrar's Sign	aliro A	parks					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#21 perPhyG782 4/10/2000 EW Reg. No 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 16:30 01 00 BABY Boy WHITE 06 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Hours Min. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 15 M 2□ F Yrs. **Director** 0 30 UNITED STATES JAN. 6, 2000 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "netural", or itema 23a or 28a-f show the Medical Evantiner must be notified at 1 ☐ Yes X ☐ No Director BALTIMORE BALTIMORE MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with t 21239 UNITED STATES 5712 LEITH WALK Funerai death 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: BLACK Specify: Aq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mentel I int: if Item 27 Is marked or FRANKLIN KATHY WHITE LLOYD MAURICE 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5712 LEITH WALK, BALTIMORE, MARYLAND 21239 19a. Informant's Name/Relationship (Type, Print) MOTHER permit. Pages 1 end 2 Department of Health e Important: if Item 27 is any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 □ Donation 5 ♥Other (Specify)Hospital Burial 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility ST. JOSEPH MEDICAL CENTER 7601 OSLER, DRIVE, TOWSON, MARYLAND James Eagan M.D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final PRRMATURITY & EXTREMB I hour Zomente disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last physician and s the buriel-tran Due to (or as a consequence of) P.O. Box 68760. certificate be Physician/Medical Due to (or as a consequence of) the USB 85 Por 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Wes en autopsy Completed peen performed? page 2 2 No 1 Yes 26 No 1 ☐ Yes certificate Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Madical Examinar: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

29c. License number

D 40175

29d. Date signed (Month, Day, Year)

8634 HAYSHED LAKOLUMBIA, MT

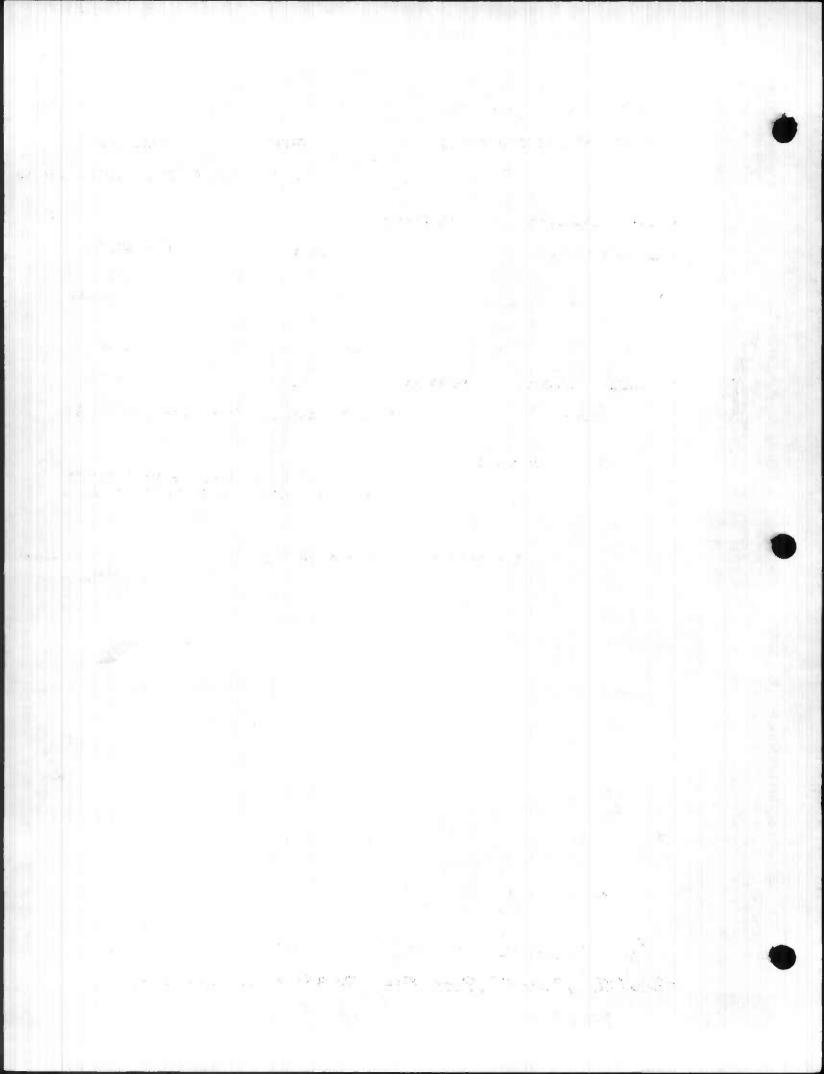
State Registrar 29b. Signeture end title of cartifier

31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

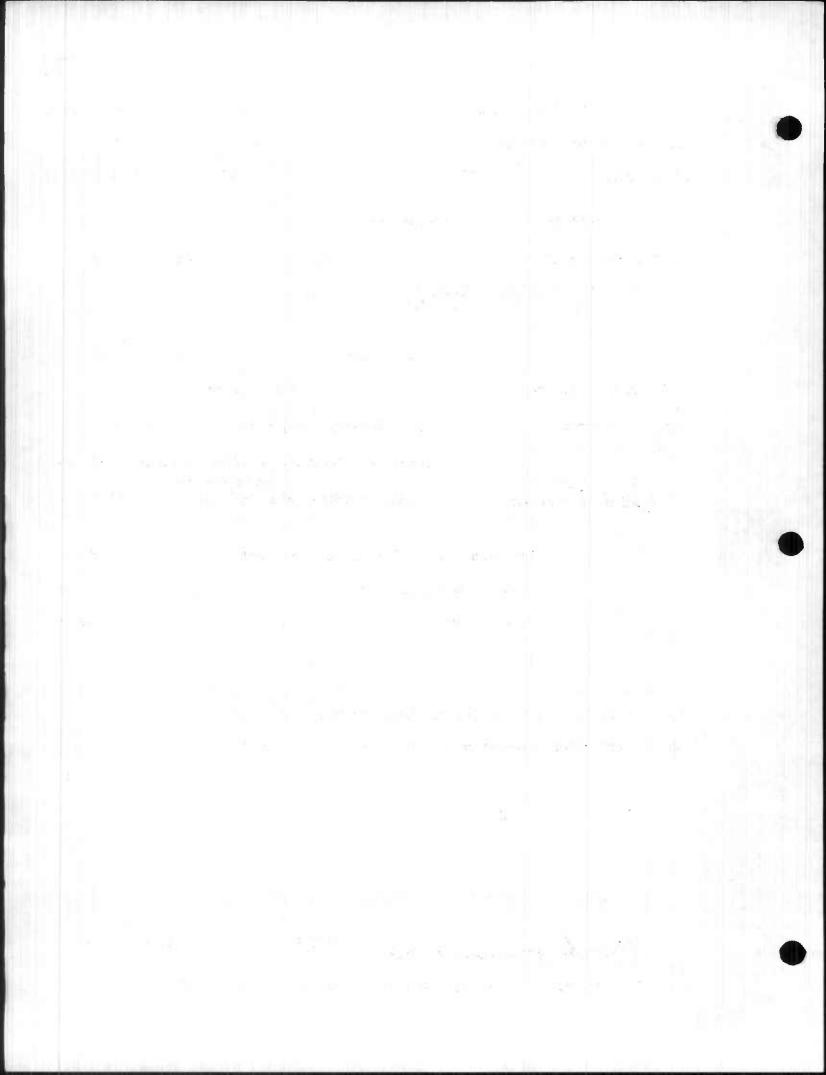
Geneva



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Daath **Physician** Month Vaar March WILLIAM CLARENCE ALLEMAN 2000 1:09 am /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Undar 1 Yaar | If Undar 24 Hrs. 8. 5. Social Security Number Data of Birth (Month, Day, Yaer) 12/4/24 Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 101M 2□ F Days Hours Yrs. Director 75 Pennsylvania 207-03-5175 Usuai Rasidance of Decedant the Marylend 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show mant be notified at 1 Yas 2 XNo Director Franklin Shippensburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò items 23a 6129 Roxbury Road 17257 United States death Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 1 IX Yas 2 No2 / 12 / 45 If Yas, Giva Yaar of Datas: 11/23/4 Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, afc.) 14. Race - Amarican Indian, Black, Whita, afc. should be filed within 72 hours efter ond Mental Hygiene. Thered other than "naturel", or item 1 ☐ Navar Married 2 Married altimore. Maryland 21215-0020 1 Yas 2 No Spacify: Specify: q 3 ☐ Widowed 4 ☐ Divorced 11/23/46 White Completed traumatic event, tre Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) T.B. Woods Co. Elemantery/Secondary (0-12) Collega (1-4or 5+) 11 Machinist Manufacturing permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event, once. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maldan Sumama) Be William C. Alleman Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) Mary E. Alleman 6129 Roxbury Road, Shippensburg, PA 17257 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Nama of camatary, crametory or other place) 20c. Location - City or Town, Stata 4 ☐ Donetion 5 ☐ Other (Spacify) Pleasant Hall Cemetery 4/1/2000 Pleasant Hall, PA 22. Nama and Addrass of Facility Davis Funeral Home Funeral Service L 12525 Bradbury Ave., Smithsburg, MD 21783 Kanes nnes 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrasf, shock, or heart feiture. List only one cause on each line. Approximata Intarval Batwe Onsat and Daath Physician /Medical Immediate Ceuse (Final Probable new cerebrovascular accident disaasa or condition rasulting In death) minutes Examiner Due to (or es a consequenca of): Physician/Medical Examiner Diabetes Mellitus vears sician end bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata causa. Enfar Undarlying Ceusa (Disaase or Injury that Initieted events rasulting in daath) Last Dua to (or as a consequance of): Hypertension 68760 vears the Dua to (or as a consaquance of): 88 Box P.O. ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Respiratory failure requiring tracheostomy and Records. by Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy ventilator; prior cerebrovascular accidents, sleep apnea complation of causa of death? page 2 1 Yas 2 No 1 ☐ Yas 2 No of Vital or Attending Physician: director, Be 25. Wes casa rafarred to medical axeminar? 26. Pleca of Daeth (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yas 2 ☑ No 1XXInpatianf 2 ER/Outpatiant 3 DOA this filled in by the funeral 27. Menner of Deeth 28b. Tima of 28d. Dascribe how injury occurred 28e. Deta of Injury (Month, Day Year) 28c. Injury et Work? After Division 5 Pending invastigation 1 Neturel 1 ☐ Yes 2 ☐ No within 24 hours after deeth. To the Funeral Oirector: A completely filled in by the fu 2 Accidant 3 Suicida 6 Could not ba 28e. Place of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifian Medical (Check only the 29b. Signature end titla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D31537 March 29, 2000 moson 30. Nama and addrass of person who completed causa of daath (Item 23e) (Type, Print) Dr. Mark Jameson, 1500 Pennsylvania Ave., Hagerstown, MD 31. Data filed (Month, Dev. Yaar) MAR 3 0 2000 32. Begistrar's Signatura State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** 28 2000 4b. City, Town, or Location of Deeth BURNS HELEN MARIE /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth Examiner WASHINGTON COUNTY HOSPITAL WASHINGTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1□ M 2⊠ F Yrs Director 235-36-5989 9. 1927 WEST VIRGINIA Usual Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at 1 X Yes 2 No Directo MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic avant, the Medical Examiner must be o 15 DELLA LANE 21713 Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify A Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 SECRETARY PUBLIC SCHOOL 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be and Mental HARVEY ARNETT BURNSIDE ETTA MAE WILLIAMS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau BERNARD J. BURNS JR./SPOUSE 15 DELLA LANE, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Dopation 5 ☐ Other (Specity) CEDAR LAWN MEMORIAL PARK 3/31/00 HAGERSTOWN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 7606 Old National Pike PaulM. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner attending physician and for use as the bunal-tran-Sequentially list conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Division of Vitai Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ECTTS p 24b. Wera autopsy findings eveilable prior to completion of ceuse of death? page 2 should Completed 24e. Wes an eutopsy After this certificate has 1 Yes 1 Tyes 2 No 2/ NK To the Hospital or Attanding Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNO 0 1 Inpatient 3□ DOA 2 ER/Outpatient 27. Menney of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Neturel 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - Al home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide

State Registrar

edical

29e. Certifier

29b. Signeture and t

31. Dete filed (Month, Day, Year)

30. Nema and address of person who completed cause

MAR 2 9 2000

**DHMH 16 Ray 6/95** 

within 24 hours a To the Funeral D

completely

32. Registrer's Signature

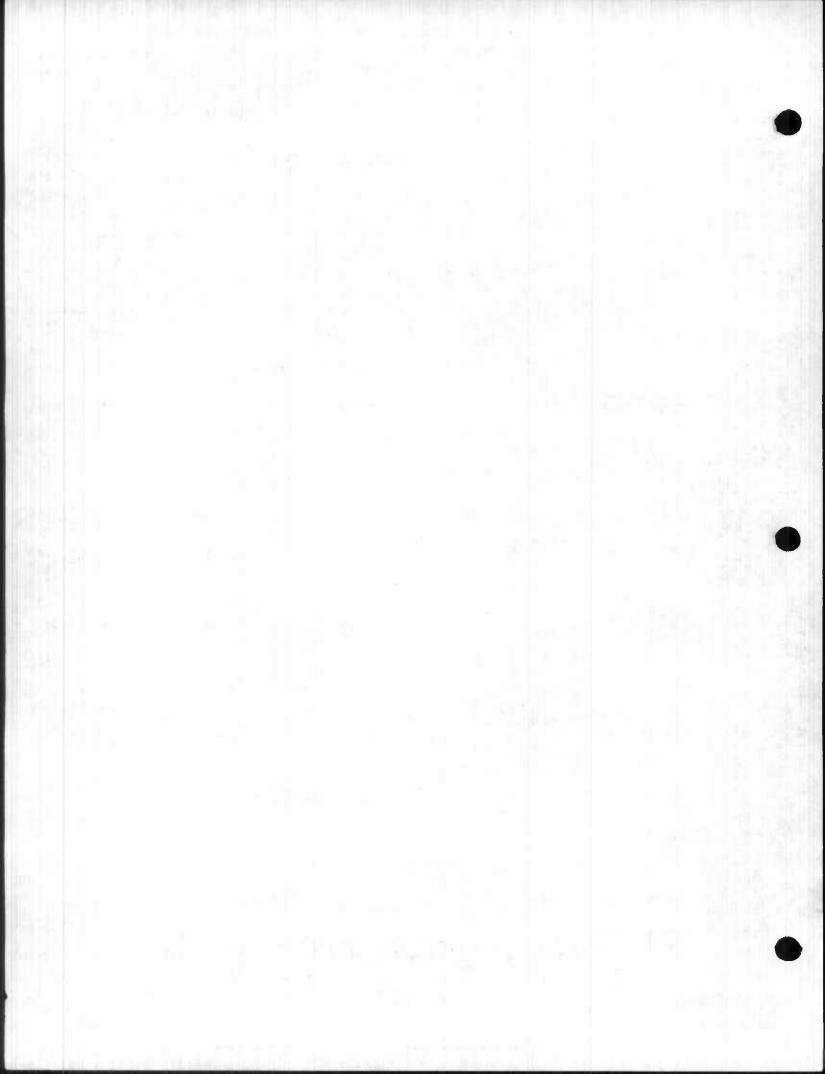
Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) and menner as stated.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

HAGENSTOWN



State of Maryland / Department of Health and Mental Hygiene

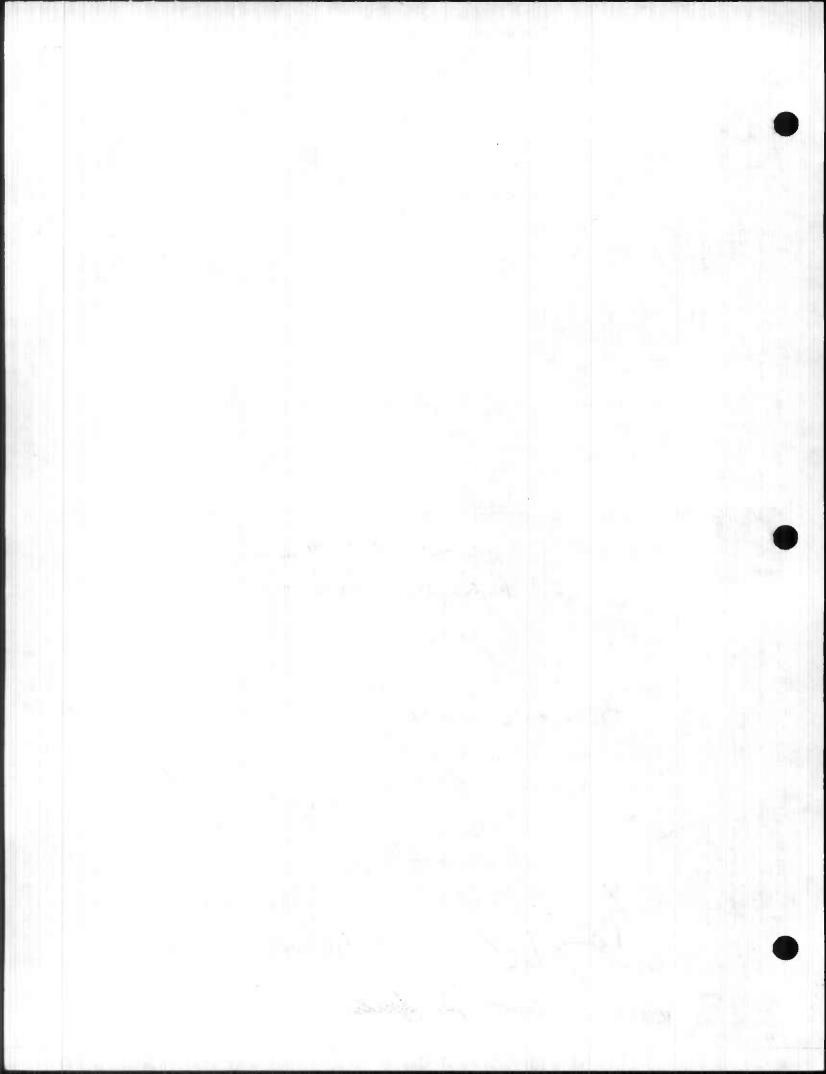
		Otato of Mary	Ce	rtificate of		, ,	log. No.	11573.
Discontinuo	1. Decedent's Neme (First, Middle, Las	()				2. Dete of Dee Month		3. Time of Death
Physician /Medical	JAMES F	RANK	BOUF	NE		MARCH	22, 2000	22:00pm
Examiner	4e Fecility Neme (If not institution, give Calvert Memorial			,	4b. City, Town, or L Prince Fre		4c. County of De	
Ement	5. Social Security Number 6. Se		n yrs. last birthday	f Under 1 Year	If Under 24 Hrs.	8. Dete of Birth (Month, Day		
Funeral Director		M 2□F	80 <sub>Yrs.</sub>	Months Deys	Hours Min.	Jan. 27		rthplace (State or Foreign Country) laryland
D .	Usual Residence of Decedent 10a. Stete 10b. County	14/	c. City, Town or L	nation				10d. Inside City Limits
laryla show								1 Yes 2 No
the N 28s-1 noutifi	Maryland Calve:	rt	Ро	rt Republ	Lic		10g. Citizen of Whet C	country?
3a or	5425 Broomes Is	land Road		2067	76		USA	
offer death with the Mark terms 23s or 28s-1 so	11. Menitel Stetus	12. Wes Decedent Eve	r in U,S. 13.	Was Decedent of	Hispenic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-	14. Race - Arr Black, Wh	
by	1 ☐ Never Merried 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 X Yes 2 □ No	1943 <b>–</b> 1945	1 ☐ Yes 2 ☒ No			Specify: B	
72 hc 72 hc	15. Decedent's Edi (Specify only highest gred	ucation de completed)	(Giv	edent's Usuel Occu e kind of work done	during most of worl	king	16b. Kind of Busines	s/Industry
flied within 72 Hygiene. Hygiene. ont, the Medic	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	Laborer	9d)		Construc	tion
be filed within 72 ho tal Hygiene. I other than 'netur went, the Madical I	17. Father's Name (First, Middle, Lest)			Laborer	18. Mother's Nem	ne (First, Middle,	Maiden Sumeme)	CLOH
Mental Mental arked o atic eve	Edward	Во	urne		Annie		Howe	
d 2 should be file th end Mental Hy 7 Is marked othe traumatic event.	19a. Informent's Neme/Reletionship (7	iype, Pnint)					r, City or Town, State,	
2 5 61 .	Delma Bourne-Parra				lan St. Up		1boro, MD	
Pege lent o mt: If	20a. Method of Disposition  1X Burlel 2 Cremetion 3 4 Donetion 5 Other (Specify,	Removal from Stete		MC Cemete		Date /28/00	St. Leonar	
pemit. Pege Department of Important: If any Injury or once.	21. Signeture of Funeral Service Licens	see //					eral Home	1- MD 20679
	23a. Part1. Enter the disease, or comp shock, or heart feilure. List only of	licetions thet caused the						Approximete
Physician	shock, or heaft fellure. List only o	one ceuse on each line.				1,		Interval Between Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition	e. Mult	is syst	tim O,	racin :	Failer	e -	Lwks
	resulting in deeth)	Du	e to (or es a conse	equence of):		-		
nsit		b. North	c Ane	wysm	Kepa	er		
execu in and iel-tra	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Du	e to (or es a conse	equency of):				
ficete be executed by physician and is the buriel-transit edical Examiner	Ceuse (Disease or Injury that initieted events	c	to (or es e conse	quence of):				
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eth cert for use		d						
at the de d by the a etached i	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the	underlying cause g	iven in Pert I.	23b. Did t		te to the cause of death?
that the hod by deta	Kenal Jailer	e, Colon	i 130	Require	(et) Lower	10	Yes 2□No 3□	Probably 4 Unknown
The law requires that the deeth certificete be executed as the best been signed by the attending physician and page 2 should be detached for use as the buriel-transit Completed by Physician/Medical Exami	100			,	10.7	24e. Wes	en eutopsy 24t	. Were eutopsy findings eveileble prior to
aw reas bee	usiem gang	real, 1	uspire	atory	Januar	e period	megr	completion of cause of deeth?
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certificate rector, pe	25. Wes cese referred to medical examiner?	Managaria (				th (Check only o	ne)	
\$ 00 D	1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpetient 28a. Dete of Injury	2 ☐ ER/Outpetie	SIL SEL DON			lence 6 Other (Sp	pecify)
ding After fune	1 Neturel 5 Pending 2 Accident Investigation	(Month, Dey Y	ear) Injury	W	ork? ]Yes 2□No	200, 2000, 20		
or Attending Physical Control of Steel Gesth. Director: After this in by the funeral din by the funeral dertification: To	3 Suicide 6 Could not be determined	28e. Plece of injury	- At home, ferm, s	treet, fectory, office			Street and Number or	Rurel Route Number,
tal or Attending P is after deeth.  In Director: After ted in by the funers Certification:	→ □ HOIIICIGE	building, etc. (	эрвсту)			City or Tou	, Siele/	
To the Heapta or Attending Physician to the Heapta or Attending Physician 24 hours after deeth. Completely filled in by the funeral completely filled in by the funeral Medical Certification: 7		rsician: To the best of miner: On the basis of ex end manner steted	aminetion end/or i					
To the comp	29b. Signature and title of certifier				se number		29d. Date signed (Mo	
	Turunash.			DS	4757		24 Murca	L'00
F. LI	30. Neme end eddress of person who con Dr. John Piet	ompleted cause of deet	h (Item 23a) (Type		Drodoni -	le MD	20679	
JTI	31. Dete filed (Month, Dey, Year)	32. Registrer's		rtince .	Frederic	K, FID	200/0	
State Registrar	MAD 9 7		mercar	4 1.				

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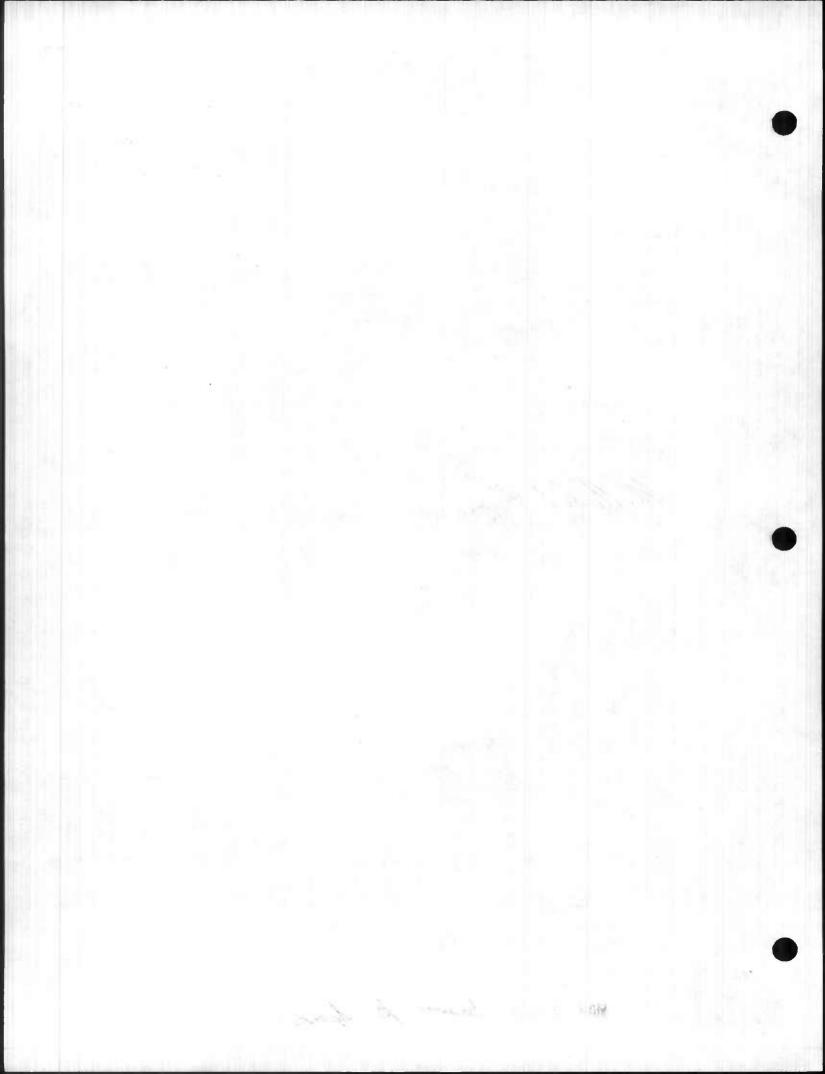
State of Maryland / Department of Health and Mental Hygiene 00 11571;

			(	Certificat	e of D	eath		Re	g. No.	0 1	110	1 24
100	1. Decedent's Name (First, Middle, L.	nst)					2. Date of	of Deet	h	Vana	3. Time o	of Death
Physiciar /Medica	C~200	Bruce					Marc		22 20 C	Year 0	115	am
Examiner	An English Manna (Mant Institution of	ve street and number)			45	. City, To	wn, or Location of I	Death	4c. County	of Death		
	Calvert County	Nursing Ce	enter				Frederic		Calver	t		
Funeral Director		Sex 1□ M 2只 F 7. Age (In yrs	i. last birth Yı	Months	1 Year Days	If Under Hours	Min. (Mont	of Birth h, Day,	Year) 1922	_	lace (State try)	
2 .	Usual Residence of Decedent  10a. State 10b. County	100 (	ihe Tours	or Location						1.0	Od Incide (	Dia a lasta
e Maryta la-f shor dilled at	Manuland Calm		*	onard							0d. Inside 0	s 2 No
ar death with the Marylar here 23e or 28e-I show not must be notified at histography.		nard Drive		10f. Zig	0685				og. Citizen of V United			
020 un an	3 ₩idowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No it Yes, Give Year or Dates:	U,S.	13. Was Dece If Yes, spe 1 Yes	cify Cuban	panic On Mexican Specify:	gin? (Specify Yes on Puerto Rican, etc.)	or No-	Blac	e-America k, White, d white	etc.	
5-0 72 ho nether dical	15. Decedent's E		16a. D	ecedent's Usu	el Occupat	ion	t of working		16b. Kind of Bu	siness/Ind	fustry	
1 21215-0020 ed within 72 hours at ygience ygience yer than "hertural", or it, the Medical Exam Commissioned by 3	(Specify only highest gi	College (1-4or 5+)		Give kind of wo ie. DO NOT u iemake:		mng mos	or working		own h	ome		
De file tai Hyg d'other event,			11011	iciiane.		18. Mothe	er's Name (First, M	iddle, N	Aaiden Sumam	Θ)		
Maryland of 2 should be file th and Mental Hy T is marked othe traumatic event		S				Myr	tle Coo	k				
and	19a. Informant's Name/Relationship	(Type, Print)	19b. k	Aailing Address	(Street a		er or Rural Route N	-	City or Town,	State, Zip	Code)	
Baitimore, Mi semit. Pages 1 and 2 bepartment of Health a reportant: If them 27 is my injury or other tre	Neal I Bruce- 20a. Method of Disposition 1  Burial 2 Cremation 3 I 4 Donetion 5 Other (Speci	Removel from State	cemetery,	crematory or o	other place	)	d Dr. S larch 25		Leona 20c. Location - 86kvil			
Bail permit Depart Import any in	21. Signature of Funeral Service Lice	nsee		22. Name an			Raus		Funer		_	
Certificate be assected ding physician and use as the burial-fransit		b. Migecar Due to	or as a co	nsequence of):	Into	taile	hon			1		
P.O. BOX												
P.O. date the date of	Pert II. Other significant conditions	contributing to death but not re	sulting in t	he underlying o	ause give	n in Part I	. 23b.		bacco uss cor			1
	trehe	ners Dis	ROSE	2				1 🗆 Ye	a 2 No	3 Prot	ably y	Unknown
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The level to the l	CEEL L.							1□ Ye	s 2 No	1 🗆	Yes 2	□ No
VITAL  Idelan: 7  Certifical  rector, p						26. Plaçe	of Deeth (Check	only on	в)			
To the side of	1 Yes No	28d. Desc	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred									
DIVISION Call or Attending P is after death.  al Director: After ted in by the funers Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				mber,					
Hospita 24 hours Funeral etely filled Closi C	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted.  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner es steted.											(s)
within To the complete of the		1		29	c. License	number		25	ed. Date signed	(Month, I	Day, Year)	
3	197	11/			1)5	194	19		3/22	100		
	30. Name and address of person who				7	nd 2	0670		/ /			
State Registrar	David Gallakin, 31. Date filed (Month, Day, Year)	M.D. Prince F  32. Registrar's Sign	eture	parks	TATA	110_2	U0/0					



State of Maryland / Department of Health and Mental Hygiene 00 11575

				Certif	ficate of	Death	F	leg. No.	11373	)
		1. Decedant's Nama (First, Middle, Last)					2. Date of Dea	ith	3. Time of De	eath
	Physician /Medical	Earl Carroll BO	WEN, Sr.				Month March	21, 2000	11:30	pm
	Examiner	4a Fecility Nama (If not institution, giva	street and number)			4b. City, Town, or L				1
		3809 Chesapeake	Beach Road			Chesapeak	e Beach	Calver	t	
	Funeral Director	5. Social Sacurity Number 6. Sep. 214 28 4524	7. Age (In yrs. le		Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Oct. 24	Year) 1925	Birthplace (State or F Country) MD	oreign
	2	Usuel Residence of Decedant	10-00							
	a Maryla Maryla short officed at	MD Calvert		; Town or Locati esapeake					10d. tnside City I	
	uth with the Marylar 23e or 28e-f show unit be notified at rai Director	10e. Street and Number 3809 Chesapeake Be	each Road		10f. Zip Code	20732		IOg. Citizen of Wh USA	at Country?	
Maryland 21215-0020	urs after des	11, Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in U,S Armed Forces? 1 ☐ Yas ②□XNo If Yes, Giva Yaar or Datas:		s Decedent of Fes, specify Cub Yas 2 □ No	lispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yes or No- Rican, atc.)	14. Race - Black, Specify:	American Indian, White, etc. White	
5-0	ed within 72 hours ygiene. At the matural, of, the Medical Em	15. Decedent's Educing (Specify only highest grade	cation completed)	16a. Decedent	's Usual Occup	pation during most of work	ina	16b. Kind of Busin	ness/Industry	
121	then the Men	Elementary/Secondery (0-12)	Collega (1-4or 5+)			during most of work d)				
2	Hygier then the Cor	8		truck	driver				ghway Adm.	
anc	A a o	17. Father's Nama (First, Middle, Last)	Parran Cm				•	Maiden Sumama)		
7	should be nd Mental marked o umatic eve	Malcolm Joseph l						Jones		
	d2:	19a. Informant's Name/Rafationship (Ty. Ethel H. Bowen (w:	ife)	PO Bo	x 332,	Chesapeal			ata, Zip Code) 1732	
Baltimore,	ages ent of tt: If it y or o	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Specify)	amovel from State Sou	ace of Disposition matary, cremato thern M	ory or other pla	rdens	Data 3-24-00	20c. Location - Ci Dunkirk		4
Balt	Departmo Importan any Injur	21. Signature of Funguer Sentiment Connections	i al		ama and Addre	nss of Facility	e. Owing	s. MD 20	736	
		23a. Part1. Enter tha disaasa, or complishock, or haart tailura. List only or	cetions that caused the death.						Approximata Interval Between	
	Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition rasulting in deeth)	CONG  Dua to (or						Onset and Dea	
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60,	rificate be axecuted on physician and as the bunk-transit	Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaase or injury	Dua to (or	as a consequer	nce of):					
x 68760,		that initiated events rasulting in death) Last		as a consequan	ice of):					
Box	at the death certi								1	
P.O.	the de ched	Part II. Other significant conditions con		^			23b. Did to		ibute to the cause of	
	be d	H 5/11	RATION				101		☐-Profeebly 4 ☐ Uri	
Records,	aw requisits been 2 should	Cornony	artery o	sh pe	ase	CUA	24a. Was a perfor		24b. Were sutopsy find available prior to completion of cau of death?	
	The la	Carrie C	- ung, en	muse (	1/2/	000	1 D Y	as 2 0 No	1 Yas 2010	5
Ita	certificate rector, pag	25. Was casa reterred to medical axaminar?				26. Place of Deel	th (Check only o	ne)		
5	N S D	1 ☐ Yas 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3LI DON			ence 6 Other		
Division of Vitai	Attending P or death.  Sector: After the by the funeral iffication:	27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day Year)	ry at rk? Yes 2 ☐ No	28d. Describe h	ow injury occurred				
Divis	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicida 6 Could not be datarmined	28a. Piace of Injury - At hor building, atc. (Specify)	ma, farm, street.	factory, office		28f. Location (S City or Tow	itreet and Number n, Stata)	or Rural Routa Numbe	N°,
	n 24 hospi n 24 hou he Funer pletely fil edical	29a. Certifier (Check only one) 1 Certifying Physical Control one) 2 Medicat Examination	Ician: To the best of my know er: On the basis of examinetic end mannar stated.	rledge, death oc on and/or Invast	curred at the ti igation, in my o	me, date and place, opinion, death occur	and due to tha d red at the time, o	ause(s) and menr date and place, an	ner as stated. d due to the cause(s)	
	To the composite of the	29b. Signatura and title of certifiar	1425)		29c. Licans	se number	0 100		Month, Day, Year)	
		Jum	1		1-1		-5 -	3/2	2100	
	12	30. Nema and address of person who co Mukesh Mathur,				D 20678				
	State Registrar	31. Date tiled (Month, Day, Year) MAR 2 3	32. Registrar's Signatu	ura	lo	2.11				



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: if tem 27 is merited other than "natural", or herrs 23s or 28s-f show any hiury or other traumatic event, the Medical Examinar must be notified at 2016s. Baltimore, Maryland 21215-0020

Donald Boernecke

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

			UE	ertificate of	Deam				g. No.		
I. Decedent's Nema (First, Midd	fla, Last)						2. Date Mont	of Death h	Day	Year	3. Time of Death
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The Memorial					East				Talk		
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DHMH 16 Rev 6/95

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Please Type or Print In Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death March 15 An Augustus **Physician** 10 twold 2000 /Medical 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Wishington Hagerston Wishington ( ounty this p. til If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 1 Yaar 6 Sex 8. Dete of Birth (Month, Dev. Yaer) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 110 M 2□ F Yrs. 75 219-12-2322 Pennsylvania Director Sept. 24, 1924 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show The Mary 1 ☐ Yes 2 No Director Maryland Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21740 USA 124 N. Edgewood Drive Berns 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Black, White, etc. 1⊠Yes 2□No 1943-MYes, Give 1943-Yeer or Detes: 46 1 □ Nevar Married 2 図 Married b 1 Yes 2 No Specify. Specify: by white 3 ☐ Widowed 4 ☐ Divorced 46 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) owner-operator tavern 11 0 17. Fether's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meiden Surneme) 8 and Mental Emma Charlotte Potter is marked Charles Herman Baker 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s ment of Health an Phyllis L. Baker - wife 124 N. Edgewood Dr., Hagerstown, Md. 21740 tem 27 Saltimore, 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removel from State Beautiful View Cem. 3-27-00 State Line, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetura of Funerel Service Licenses Name end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 200 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Betwaen Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical 24hrs Examiner Due to (or es e consequence of) Physician/Medical Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last the burial-tran Due to (or es e consequence of): 68760 Due to (or as a consequence of) Box ( been signed by the a should be detached P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. by Be Completed 24a. Wes an eutopsy 24b. Were autopsy findings available prior to completion of cause of death? performed? hes 2 DNo 1 Yes 1 ☐ Yes 2 ☐ No this certificate al or Attending Physician: The safter death.

I Director: After this certificate of in by the funeral director, pa 25. Wes case referred to medicel axaminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) within 24 hours efter der To the Funeral Director completely filled in by th 3 Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier

State Registrar

31. Dete filed (Month, Day, Year) MAR 2 4 2000

29b. Signeture end title of certifier

Ne. 1 8malley

11110 rudical 32. Registrar's Signeture

end manner statad.

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

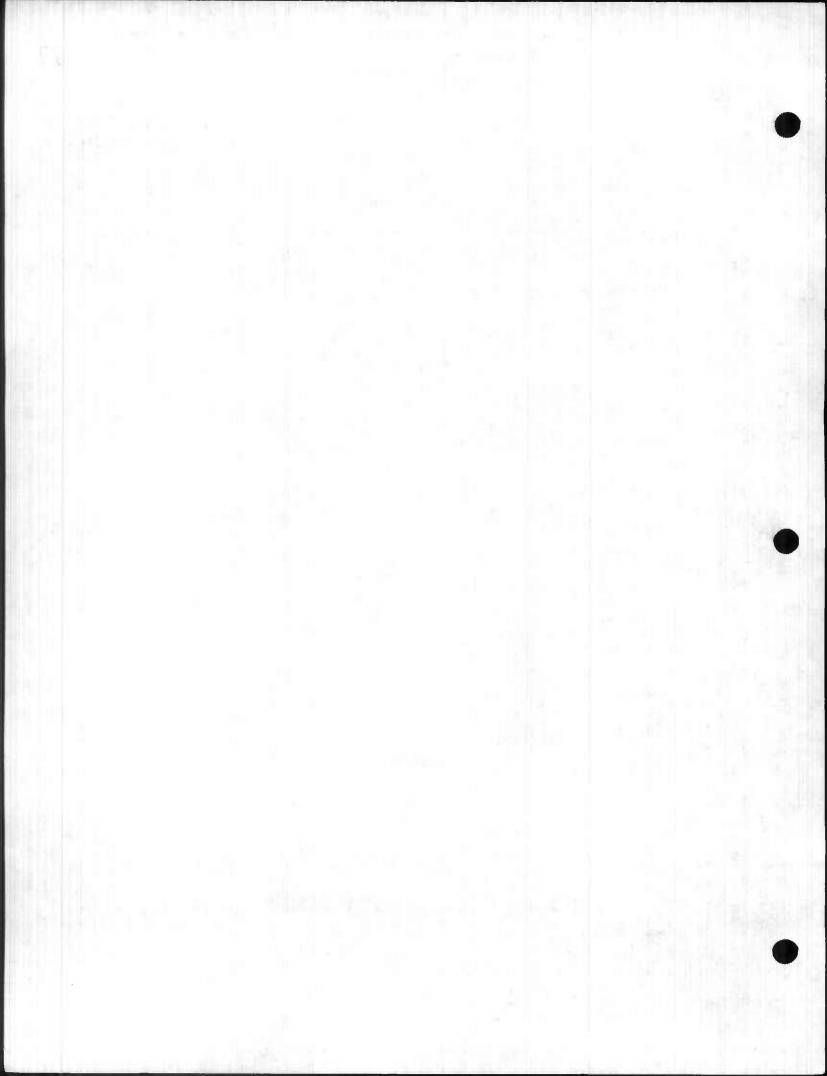
29c. License number

1)50813

29d. Date signed (Month, Dey, Year)

March 22, 2000

Rad Site 127 Hageston, MO 21742



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Lula Satoria BUSH 30 6:55 pm 2000 Mar /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Fahrney - Keedy 5. Social Security Number 6. Sex Home (ear) 9. Birthplace (State or Folding) If Under 24 Hrs. 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Hours Months 1 □ M 2 🗓 F 103 Yrs Director 219-20-4958 Oct. 2,1896 Maryland Usuel Residence of Decedent show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Mexical Examinar must be notified Director Maryland Washington 1 Yes 2 No Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 904 Mulberry Avenue 21740 Funerai USA 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 \*natural', or 1 ☐ Yes 2 ☒ No Specify: Specify: by white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 clerk retail sales 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 end 2 should be f ment of Health end Mental I ifem 27 is marked Elmer Funk 2 Jennie Foltz 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Martha R. Byrd-granddaughter 19120 Olde Waterford Rd., Hagerstown, Md. 21742 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or of 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 4/3/00 Hagerstown, Maryland 21. Signature of Fuperal Service Lic 22. Name end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagers

238 Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximete fnterval Between Onset end Deeth Physician /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Antenionaladia Cardiovaranda Drun **Examiner** Due to (or es e consequence of): Examiner lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest use es the buriel-tran end Due to (or es e consequence of) of Vital Records, P.O. Box 68760. ete hes been signed by the ettending physician page 2 should be detached for use es the burie Physician/Medicai Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Parkinga D'ren by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy within 24 hours after death.

To the Funeral Director: After this certificate hes 2 400 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28d. Describe how Injury occurred Division 5 Pending Investigation Attending 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 4 Homicide 1 Cartifying Phyeicfan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner es steled.

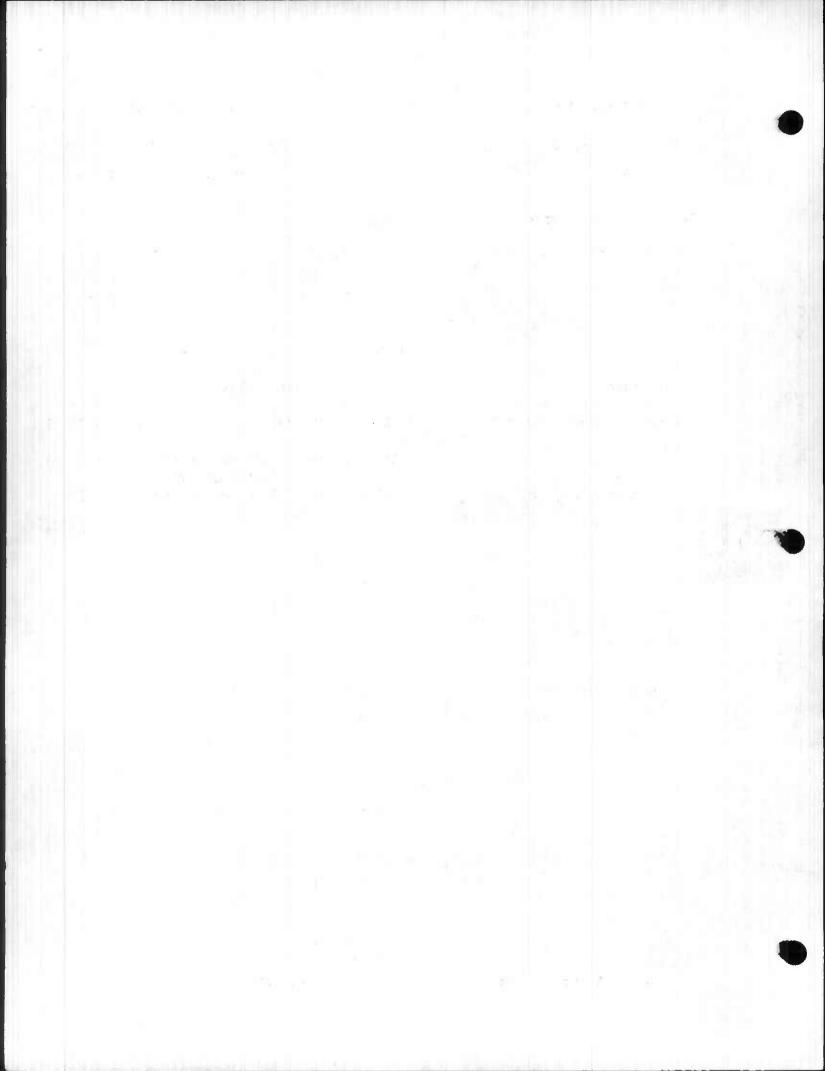
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steled. 29a. Certifler Medical (Check only one) the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) word MD P1081 Q MARCH 31, 2003 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. V. Datta, 334 Mill Street, Hagerstown, Md. 21740 31. Dete filed (Month, Day, Year)
MAR 3 1 2000 32. Registrar's Signeture Registrar

DHMH 16 Rev 6/95

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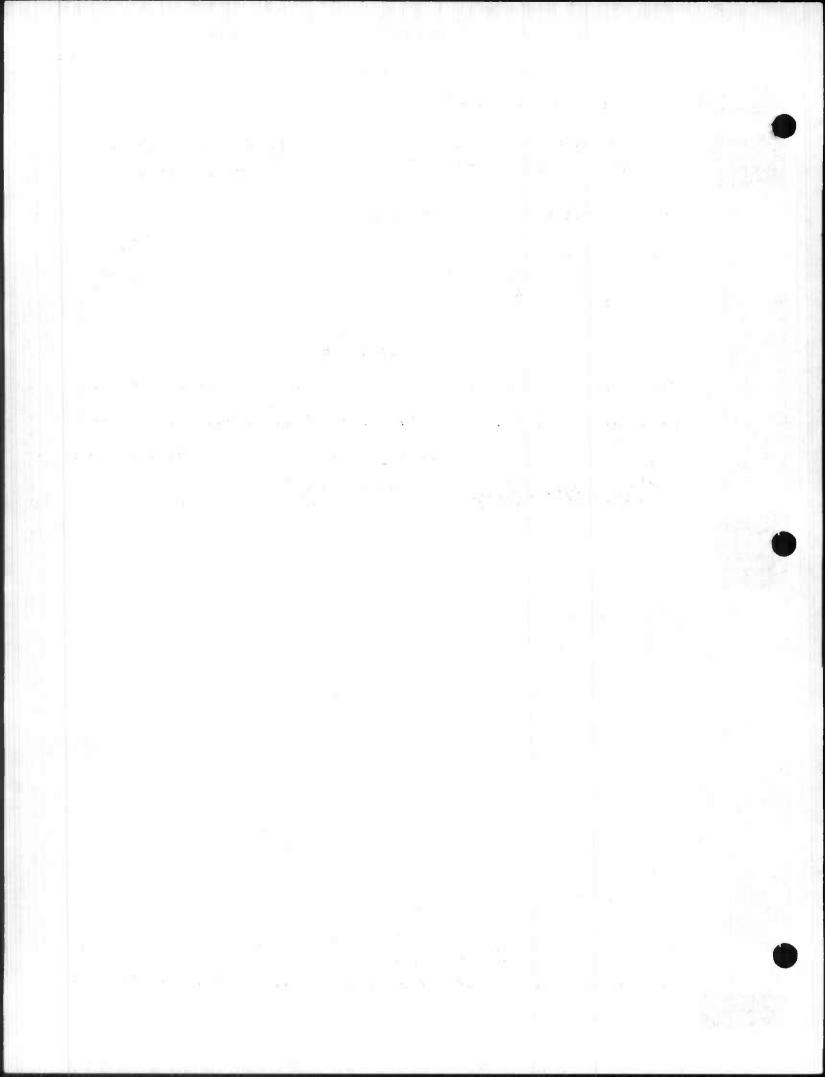
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 1 5 7 9

						Certificate o	f Death	F	Reg. No.		
	Physic	an	1. Decedent's Nama (First, Middla, I Charles Laur	ast)	11			2. Data of Dea Month	ath	Year	3. Tima of Death
	/Medi					<u>-</u> .	1	April	01 20	000	6:30a.m.
	Exami	ner	4a. Facility Nama (If not institution, g	The contract of the contract of			4b. City, Town, or		,		
			Caroline Nursi			hday) If Undar 1 Ya		Maryland		line	
	Funeral Director		182185724	121 M 2□ F 7	(In yrs. last bird	Yrs. Months Day			Y, Year) 1,1923	9. Birthp Coun	iaca (Stata or Foraign try) Penn.
	anyland show dat	-	Usual Residence of Decedent  10a. State 10b. County  Md. Caroli	n e	10c. City, Town	or Location sboro				1	0d. fnsida City Limits
	Ne M	cto									77.5
	ith with the 23a or 2	Funeral Director	12539 Greensb	oro Road		10f. Zip Code 2 1	639		10g. Citizan of t	What Coun USA	try?
020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mertal Hygiene. If health and Mertal Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Exercited result be notified at	by	11. Marital Status 1 □ Nevar Married 2 □ Marriad 3 □ Widowed 4 ☑ Divorced	12. Was Dacedant E Armed Forcas? 1 Yas 2 N If Yas, Giva Yaar or Datas:	10/1/1	13. Was Decedent of If Yas, specify Co	f Hispanic Origin? (Suban, Maxican, Puari Specify:	Specify Yas or No- to Rican, atc.)	14. Rac Blac Specify	e - Amaric ck, White, Whii	atc.
5-0	72 ho	eted	15. Decedant's (Specify only highast g	Education	16a.	Decedant's Usual Occ (Giva kind of work dor	cupation	rkina	16b. Kind of B	usinass/Inc	lustry
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	and 2 should I alth and Meni 27 Is marked or troumatic		19a. Informant's Name/Ralationship Ralph J. Caha			Mailing Addrass (Street d 1 Box					
Baltimore,			20a. Mathod of Disposition  1 Burial 2 Cramation 3  4 Donation 5 Other (Special Control of Control		cematar	Disposition (Nama of y, cramatory or other p rsity of		Data 4/1/00	20c. Location - Newar	City or To	wn, Stata e • 1 9 7 1 6 - 2 5 9 1
Balt	pemit. Page Department of Important: If any Injury or 2002.		21. Signature of Funeral Service Lic	Paoor		1000 E	unerai H			1	and 2162
	Physician /Medicai Examiner	er	23a. Part1. Entar tha disaasa, or co shock, or heart failura. List on Immediata Causa (Final disaasa or condition rasulting in death)	. Metast	atical	consequence of):	yying, such as cardiad	c or raspiratory ar	7951,		Approximsta fritarval Batween Onsat and Death
x 68760,	leath certificate be executed attending physician and I for use as the burial-transit	/Medical Examiner	Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		consequance of):					192.
Box	atter	Physician/	Part II. Other significant conditions	contributing to death bu	t not rasulting In	tha undarlying causa	given in Part I.	23b. Did t	obacco use co	ntribute to	the cause of death?
P.O.	that ed b dets			-				101	res 2 No	a Prot	pably 4 Unknown
of Vital Records,	aw requires is been sign 2 should be	Completed by						24a. Was perfor	an autopsy med?	av.	ara autopsy findings allable prior to mpletion of causa death?
<u> </u>	0 - 0	200						1 🗆 Y	as SENo	10	Yas 2 No
ita	ysicien: The s certificate director, per	Be	25. Was casa rafarred to medical axaminar?				26. Place of De	ath (Check only o	na)		
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	To the Hospital within 24 hours of To the Funeral Completely filled	edical (	29a. Certifiar (Check only one) Certifying F	hysician: To the best of miner: On the basis of and manner state	axamination and	, death occurred at tha d/or invastigation, in m	tima, data and place y opinion, daath occu	e, and dua to that urred at tha tima, o	cause(s) and madata and place,	annar ss st and dua to	sted. tha cause(s)
	Withiu To the Comp	M	29b. Signature and title of certifier	N	1	29c. Lica	nsa number		29d. Date signe	d (Month,	Day, Year)
			30. Nama and addrass of person wh	complated hause of de	eth (Varn 22a)	Type Print)	5048		4/1	12	000
			Eric F. Cigan		4.5	ntrevill	e Rd., C	Centrev	ille,	Md.	21617
	Sta Registr		31. Data filed (Month, Day, Year) APR 0 3	32. Registra	r's Signatura	B. Spa	Ks				



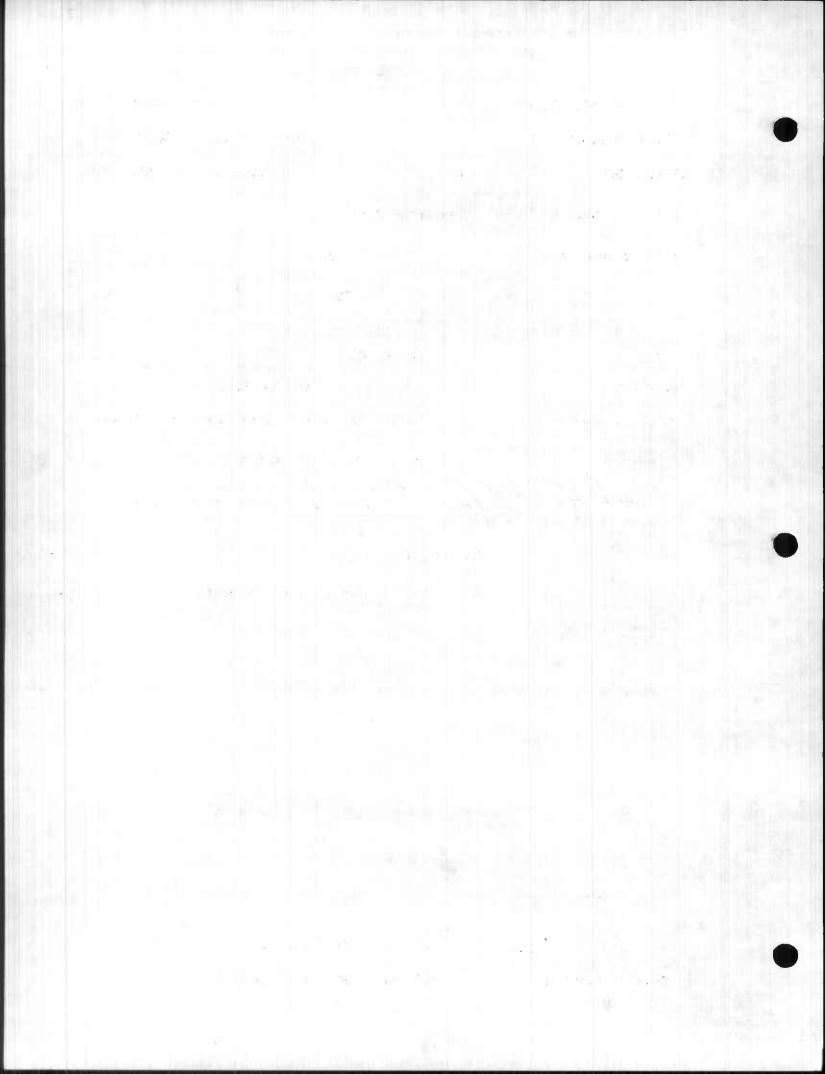
Milton W.	. Collins, Sr.		nd / Department of Certificate of		Reg	i. No.	11580						
Physician /Medical	INITION NA	IDON Collin	s SR		2. Date of Death Month March 26		3. Time of Death 7:40 P.M.						
Examiner	4a Facility Name (If not institution, given 11293 Greenwood			4b. City, Town, or Princess	Location of Death	4c. County of Deat Somerset							
Funeral	5. Social Security Number 6. S		last birthday) If Under 1 Ye	nar If Undar 24 Hrs	8. Date of Birth		hplace (Stata or Foreign untry)						
Director	218-40-6514 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	54Yrs. Months Da	ys Hours Min	08-01-	45	MD						
s Marylan Sa-f show diffed at	MD 10b County  Ome	- T	incess	) e			10d. Inside City Limits 1 XYas 2 No						
ther death with the Ma inner must be notified funderal Director	10e. Street and Number	1 64 1	RD 10f. Zip Cod		10g	2. Citizen of What Co	untry?						
South Tree 23	11243 GREENWO	12. Was Decedent Ever in U	S. 13. Was Decedent	31853 of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame							
		Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	If Yes, specify C	luban, Mexican, Pue No Specify:	rto Rican, atc.)	Black, White	9, etc.						
M. Exam		Year or Datas:				Specify. B	lAck						
in 72 in 85 indica	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation ne during most of wo tired)	orking 16	6b. Kind ot Business/	Industry						
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Mam 3 and a state of the state	20a. Method of Disposition	20b. F	Placa of Disposition (Name of	niace)		c. Location - City or							
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aparti aparti ny inj	21. Signature of Funeral Service Lice	7/	R2. Nama end Ad	drass of Facility	Funeral +	Home							
4 40546	Hullwyle.	Word	30639 Han		Princess Ar	nne MD	21853						
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a Hyper	tensive	- an	dai	terios	clerotic						
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te be axecuted by sician and to burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (c	or as a consequence of):										
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le law requires that has been signed to ge 2 should be dett					24a. Was an		Were autopsy findings available prior to						
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ysicien: The law is certificate has to director, page 2 s	25. Was case reterred to medical				eath (Check only one)	)							
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ding After After fune	27. Manner of Death 1 Netural 5 Panding 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation 28d. Describe how injury occurred Work? 1 Yes 2 No												
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Within To the comp	29b. Signature and Nie of certifier		29c. Lic	ense number		d Date signed (Mont							
	1	estani		O.C.M.E.	Ma	arch 28, 2	2000						
37	30. Name and address it person who	completed cause of death (Iter											
	1 100	seph restr	UNCUL111 Penn S	Street, Ba	ltimore, M	Maryland 2	1201						

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 115

	1. Decedent's Name (First, Middle	e, Last)				of Death	2. Dete of Dee			3. Time of Deal	
Physician	Alma Vada	Elburn					March 2	20, Dey 2000	Yeer	8:40 A	
/Medical Examiner	4a Fecility Neme (If not Institution	n, give street end number	)			4b. City, Town, or	Location of Deeth	4c. County			
	21064 Arizona	Lane				Lexingto	n Park	St. M	lary's		
Funeral Director	5. Sociel Security Number 217-38-6588 Usual Residence of Decedent	6. Sex 1 ☐ M 2X F	ge (In yrs. last		f Under 1 Y Months De	ys Hours Min		Year) 12, 193	Country		
B ==	10e. Stete 10b. County		10c. City, T	own or Locat	tion				100	I. Inside City Lin	
in pi	Maryland St.	Mary's	Lexin	gton P	Park					1   Yes 2	
items 23s or 28s-f show at roust be notified at uneral Director	Maryland St. 1 10e. Street and Number 21064 Arizona L	ane			10f. Zip Cod 2065			10g. Citizen of W	itizen of Whet Country?		
	11. Meritel Status  1 Never Married 2 Marr  3 Vidowed 4 Divorced	12. Was Deceden Armed Forces ied 1 Yes 25 If Yes, Give Yeer or Dates:	? I No		s Decedent es, specify	of Hispenic Origin? ( Cuben, Mexicen, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.  Specify: White		o.	
nd Mental Hygiene. merked other than "natural", or imatic event, the Medical Exert To Be Completed by F	15. Deceden (Specify only higher Elementery/Secondery (0-12)	t's Education st grade completed) College (1-4or	5+)	6e. Decedent (Give kin- life. DO	of work de NOT use re	ecupetion one during most of wo tired)	orking	16b. Kind of Bu	siness/Indu	stry	
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i Health and Mental Is tem 27 is merked of other trsumatic eve To Be	19e. Informent's Name/Reletions	hlp (Type, Print)	1	19b. Malling A	Address (St	reet end Number or F	lurei Route Numbe	r, City or Town,	Stete, Zip C	ode)	
r tre	Joseph D. Elbur	n/ Son	1	06 Wat	terman	's Court,	Grasonvi	11e, MD	21638	3	
Department of Hea Important: if Item eny Injury or othe 2008.	20e. Method of Disposition  **Surial 2 Cremetion 4 Donetion 5 Other (S)	3 ☐ Removel from State	ceme	of Disposition of Dis	tory or other	f plece) etery Ma:	Date	20c. Location -			
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page 2 should be det completed by P								med?	eveil com of de	e eutopsy findir able prior to pletion of ceuse eth?	
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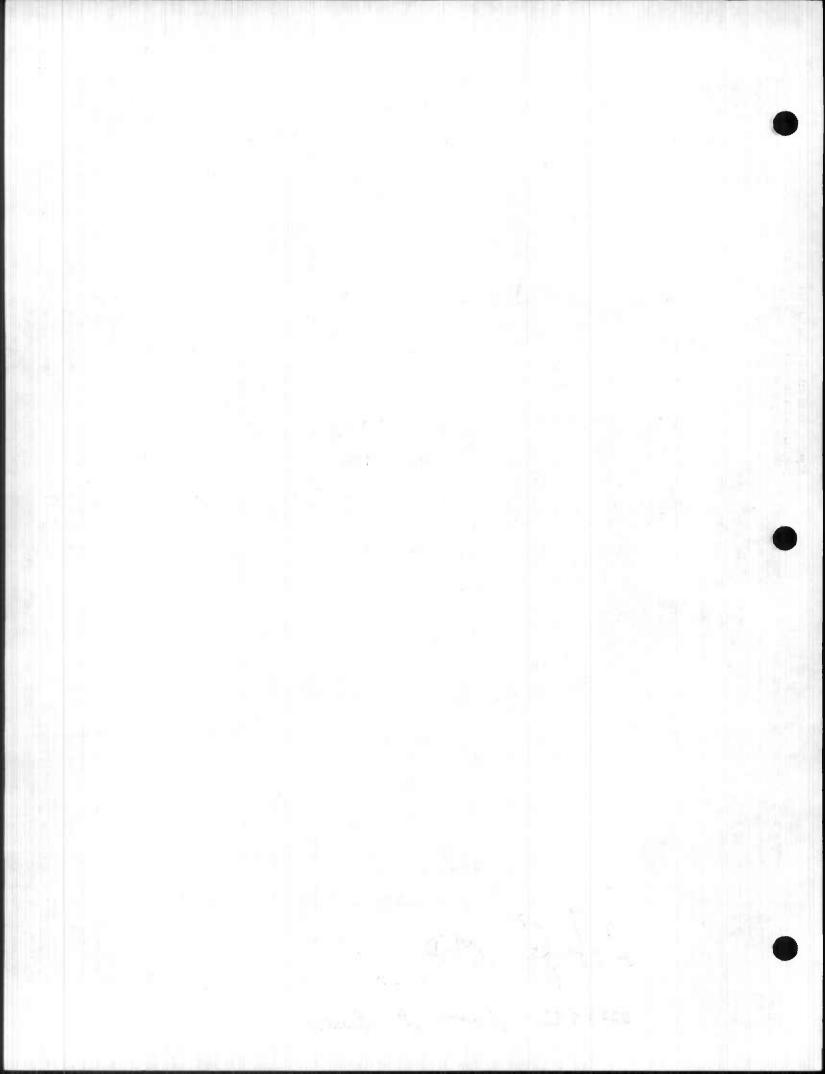


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

				Ce	nincat	e or	Death		Reg. N		0 1	1302
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Physician /Medical	HOLLAND	DALE		FRED	ERICH	<		MARC		, 200	OO	10:15 F
Examiner	4a Facility Name (If not Institution VA MARYLAND HE		•			1 0	4b. City, Town, or PERRY F			c. County		
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Funeral Director	235-03-9281	1 <b>X</b> M 2□ F	84	Yrs.	Months	Days	Hours Mir		Dey, Year 1916	7)	Count	VIRGIN]
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or 28s-f at be notified be notified	10e. Street and Number	noe i	PRIN	CESS	10f. Zip	Code			10n C	itizen of W	Vhat Count	
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ther death v r hama 23a siner.must Funeral	11. Marital Status	12. Was Deceden	t Ever in U,S	S. 13.	Wes Deced		dispanic Origin? ( an, Mexican, Pue	Specify Yes or	No-	14. Race	e - America	
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un sell de	Elementary/Secondary (0-12)	Coilege (1-4o	5+)	life.	DO NOT us	e retire	d)	Sinary				
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B even	17. Father's Name (First, Middle,						18. Mother's Na				Θ)	
D 6 8 0	THOMAS WADE FF	REDERTCK					SALLIE	JANE FR	EDERI	CK		
2 sh and le m	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mail	ng Address	(Street	and Number or F	Rural Route Nur	nber, City	or Town,	State, Zip	Code)
and	BRUCE FREDERIC	CK/SON					/ENUE, A	BERDEEN		210		
mit. Pages 1 and 2 shou positionit of Health and M portanti if Item 27 is mer y Injury or other traumat Ge.	20a. Method of Disposition 180 Buriel 2 ☐ Cremation	3 DRemoval from State		metery, cre	osition (Nan metory or o	ne of ther ple	ce)	Date	20c. L	_ocation -	City or Tov	m, State
Pag ment ury ury	4 Donation 5 Other (S			URY C	EMETE	RY		3/29/00	MT.	VER	NON.	MD.
permit. Pa Department Important: any injury office.	21. Signature of Funeral Service	Lipupson		2	2. Name an	d Addre	ss of Facility					
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TO STATE OF	Part1. Enter the disease, o shock, or heart tailure. List	complications that cause	ed the death.	Do not en	ter the mod	e of dyir	ng, such es cardie	ac or respiratory	errest,	AUUU	E., MD	Approximate Interval Between
Physician	Shock, or heart tailure. List	t only one cause on each	iirie.									Onset end Death
/Medical	Immediete Cause (Final disease or condition	AS	SPIRAT	ION P	NEUMO	AIN					1	UNKNOWN
Examiner	resulting in deeth)	â	Due to (or	as a conse	quence of):						1	
P ~		AI	ZHEIM			CIA						UNKNOWN
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Sequentially list conditions,	Б.		as a conse								OTHEROVITA
an a urial-	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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d by the attend etached for us	Part It. Other significant condition	ons contributing to death	but not resul	ting in the u	inderlying c	ause giv	ven in Part I.	23b. D	ld tobacc	o use con	tribute to	the cause of de
at the								1	☐ Yes	2□ No	3 Prob	ably 4 Unki
igned be de												
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The la								10	☐ Yes 2	2 🗱 No	10	Yes 2□ No
certificate rector, pag	25. Was case referred to medica	al					26. Place of De	eath (Check on	y one)			
hysician: nis certific Il director, To Be	axaminer? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatie	nt 3 DO	A Oth	201	Home 5□Re		8 Othe	er (Specify	)
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er this neral d		igation (Monn, D	oy roar,	enjury	М		Yes 2 □ No					
ath. r: After thi a funeral atton: 7	2 LI Accident		njury - At hon	ne, farm, st	reet, fectory	, office			(Street a		er or Rural	Route Number,
Attending Phar death.  •ctor: After thiby the funeral by the funeral tiffication: 1	2 Accident investi 3 Sulcide 6 Could	nined 200. Place of the	do (Spaning)					Ony or	Own, Star	10/		
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 348 MARCH 27 Gray John F. 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner MARYLAND HOSPITAL PRINCE GEORGES SOUTHERN CLINTON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** 1 DXM 2 □ F Months Deys Hours Min. Yrs November 29, 1927 72 Maryland **Director** 554-40-2095 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 1 and 2 should be filed within 72 hours efter death with the Maryla Health and Maniel hygiens.
1 sem 27 is merked other than "naturel", or items 23a or 28a-f show other traumatic event, the Mariesa Example main by notified. 1 XYes 2 No Directo Maryland Charles Brandywine 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 15100 Regina Avenue 20613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Custodian P.G. Bd. of Education 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Thomas Gray Rose Edelen 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Wife Mary L. Gray-15100 Regina Avenue Brandywine, Maryland 20613 item 2 altimore, 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If iter any Injury or oth page. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.Marys Cemetery 3/31/2000 Bryantown, Maryland 22. Name and Address of Fecility 40 M00191 Adams Funeral Home P.A. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical · ARTELIOSCUEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Physician/Medical Examine physicien end s the burial-transit The law requires that the death certificeta be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): P.O. Box 68760, Due to (or as a consequenca of): attending phy resulting in death) Lest Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by I 1 Yee 2 No 3 Probably 4 Nunknown VIABETES MELLITUS Division of Vital Records, þ 24b. Were autopsy findings avelieble prior to completion of cause of death? 24a. Was an autopsy performed? Completed ALZHEIMERS DISEASE cartificete has b lirector, page 2 s 210 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 AER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this Director: Aftar thi 27. Magner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Hospital or Attending 5 Pending investigation Natural deeth. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) and menner es steled.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, end due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi edicai 29d, Dete signed (Month, Dev. Year) 29c. License number 29b. Signature and fi 2000 death (Item 23a) (Type, Print) 30. Name and eddress of person who completed cau CHOVERLY 300 HOSPITAL MARIO F. GOLLE

State Registrar

31. Date filed (Month, Day, Year)

MAR 3 0 2000

32. Registrer's Signature

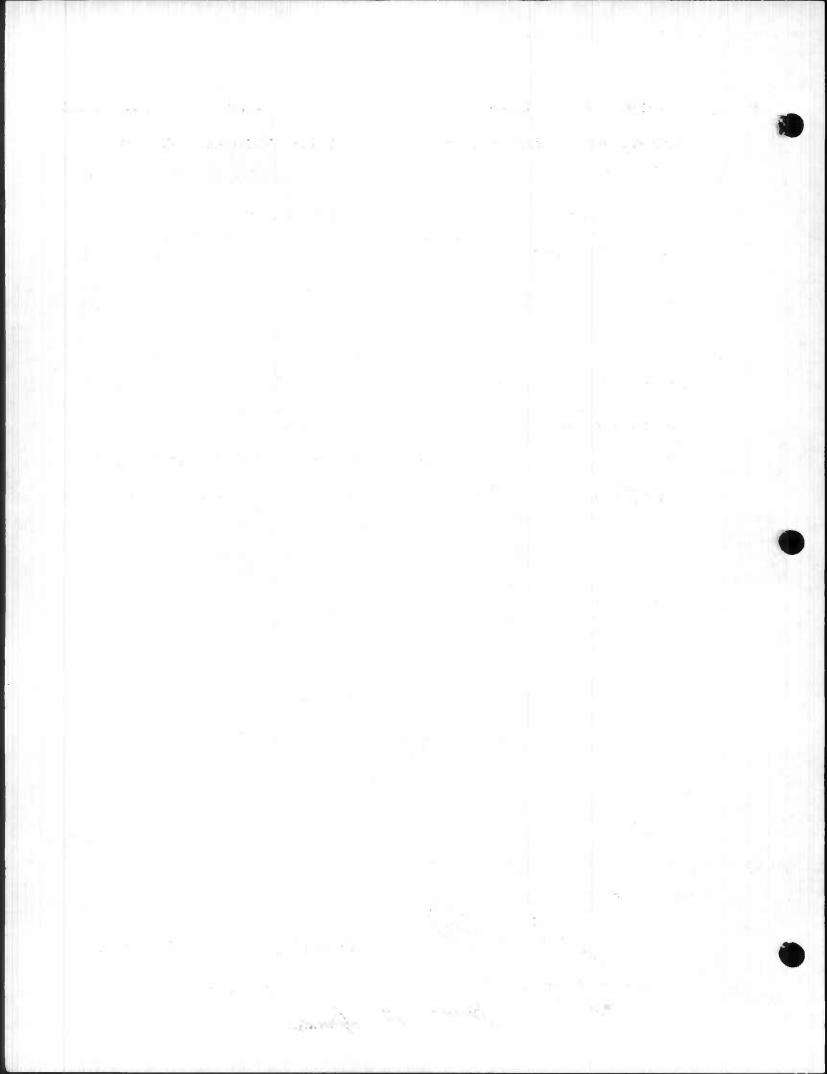


State of Maryland / Department of Health and Mental Hygiene

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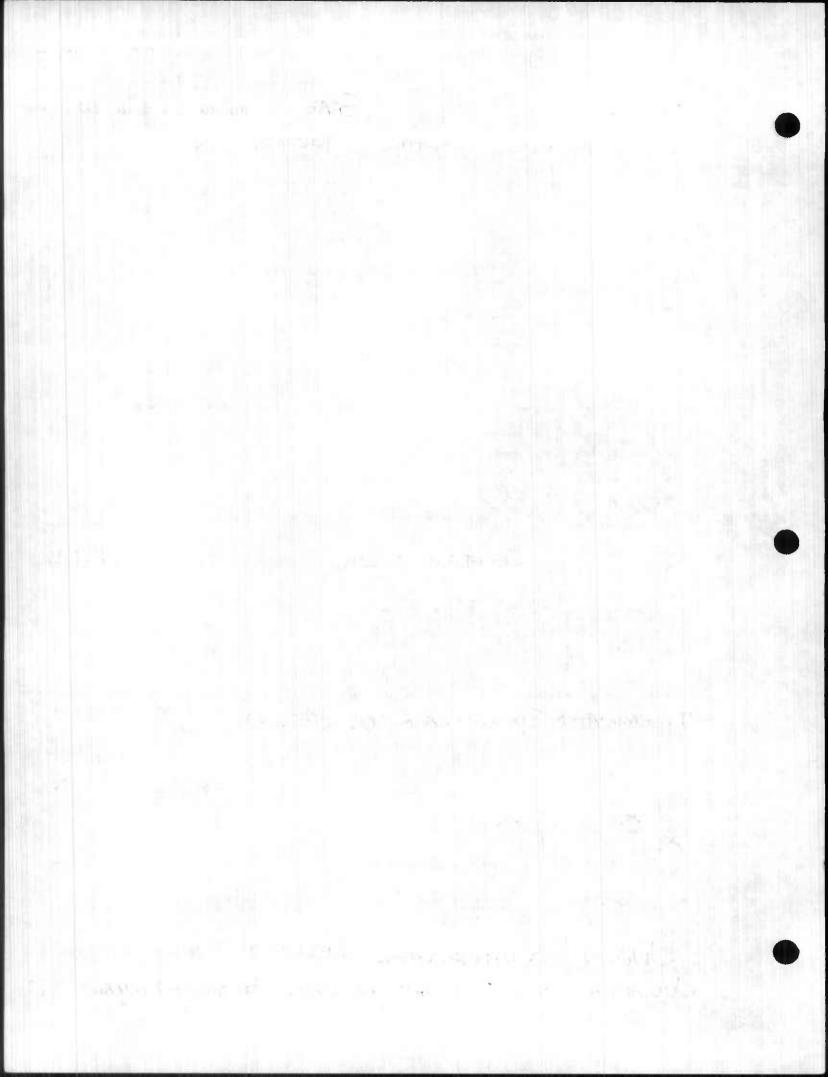
						Cer	tificate of	Death		Re	eg. No.			8
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	Funeral Director			JM 2√2 F	91	Yrs.	Months Deys	Hours	Min.	8. Date of Birth (Month, Dey,	Year)	Coun	leca (Stata or Forei	yii.
			Usuel Residence of Decedent							Dec 10,	1900	Virg	IIIIa	
	land		10a. Stete 10b. County		10c. City, T	own or Loc	ation					1	0d. Insida City Limit	ts
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	the 288	Director	10e. Street end Number		1		10f. Zip Coda			140	Og. Citizen of \	Mhat Cour	to/2	
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ž	should be filed within 72 hours after death with the Manyand nd Mental Hygiene. I marked other than "natural", or items 23a or 23a-f show umafic event, if a Madical Evariner must be notified at	2	Sander Houseon	AIMETEL										
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	ss 1 end 2 should be filed within 72 hours after death with the Manylan of Health end Mental Hygiene. Itam 27 Ia marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Evaritiner must be notified at		Fred Garber / son			-	as # 1	0 abov	e					
<u> </u>	O H		20e. Method of Disposition 1 Sur Burial 2 □ Cremetion 3 □ F	lamaval from State	20b. Plece ceme	of Dispos etery, cram	ition (Nama of atory or other ple	эсе)		Dete :	20c. Location -	City or To	wn, Stete	
ltimore,	Pages nent of h ant: If Its ury or of		4 □ Donetion 5 □ Other (Specify)	amover nom Stete	Ft.	Linco	1 Cemet	ery	3	-27-00	Brenty	rood,	MD	
a	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funerel Sarvica Licens	99		22.	Nama and Addr	ess of Facility	у					
m	205 20		1 William	K Th	2000	R	ausch I	Funera	al H	lome, F	A.,	Owin	gs, MD	
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	icete be executed physician and s the burlet-transit	Exa	Sequantielly list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury	(-	Due to (or es	e consequ	ence of):	Accord	la t	- / -	1.11	):		
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or vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medicel examiner?						of Deeth	(Check only on	a)			
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	n 24 in 24 he Fi	edical	(Check only 2 Medical Examination)	and menner sta	ited.	and/or inva	istigetion, in my	opinion, deeti	n occurre	d et the time, de	ete end place,	and dua to	tna ceuse(s)	
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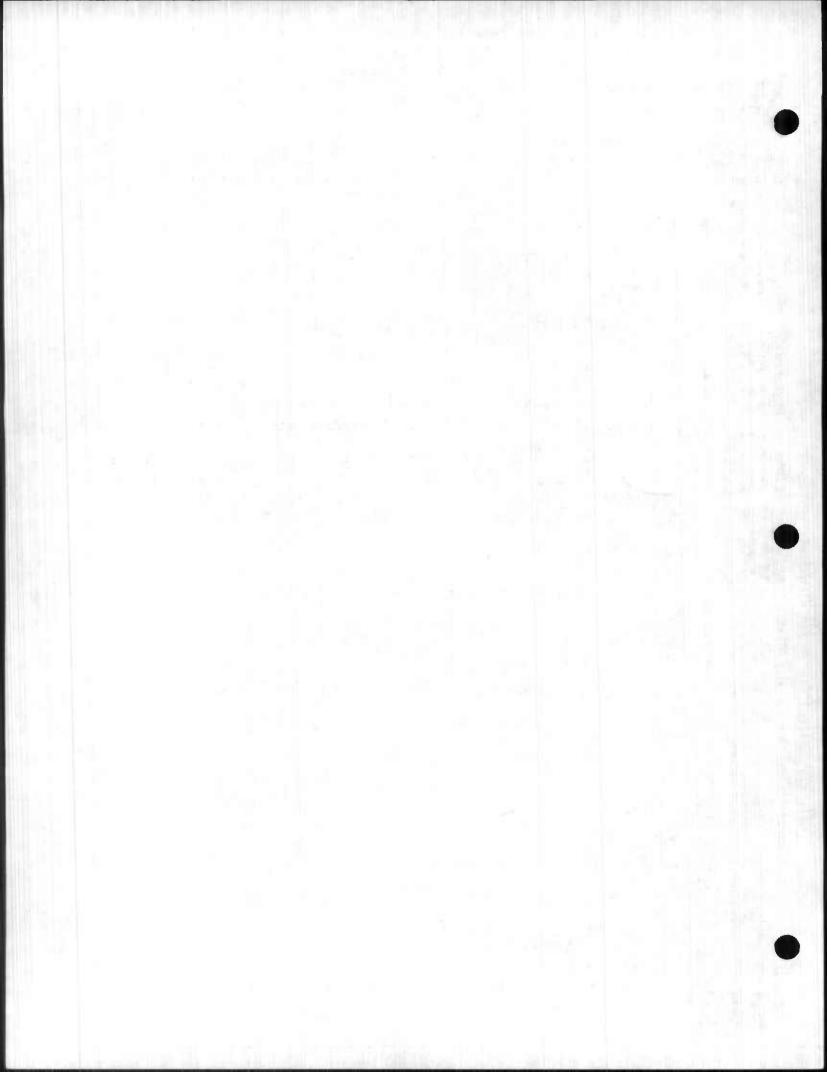
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with the Maryland as or 28s-f show t.be notified at	10a. State 10b. Cour			10c. City, T	Town or Lo	cation							10	0d. Inside City Limits
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r items 23u siner must Furneral	11. Marital Status		12. Was Decedent Armed Forces		13. \	Wes Dece	dent of H	ispanic On in, Mexicar	gin? (Sp	ecify Yes or No Rican, etc.)	0- 1-		America White,	an Indien, etc.
大百 4		larried	1 ☐ Yes 2 ☒ If Yes, Give			1 ☐ Yes		Specify:						
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		lle, Last)				4		18. Mothe	r's Nam	e (First, Middle	, Maiden S	iumeme)		
To Be	Charles Loui	is Gr	ab, Sr.					E1:	izab	eth Pea	rl Be	ckle	2 У	
-	19a. tntorment's Neme/Relation				19h Mailir	na Addres	s (Street	and Numb	er or Ru	al Route Numb	ner City or	Town St	ete Zin	Code)
train.	Charles W. Gr													
ž		.ab,	JI. DI		e of Dispo			Lie F.	LKe.	Dete		ration - Cit		d 21740
8	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation	n 3 □F	Removal from State	com	etery, cren	netory or	other plac	(e)	1	111111	100			
5	4 Donation 5 Other	(Specify)		Res	st Ha	ven (	Cemet	ery	3-	-25-00	Hage	rsto	wn,l	Maryland
	21. Signature of Funeral Servi	ice Licence	ee	- /	7 22	2. Name a	nd Addre	ss ot Facili	y M	INNICH	FUNER	AL H	OME	
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	23a. Part1. Enter the diseese,	or compl	ications that cause	d the deeth.	Do not ent									Approximete
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iner	Immediate Cause (Final disease or condition resulting in deeth)  a. CERERAL EDEMA													12 hRS.
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8	29b. Signeture and title of certi	iiier (					c. Licens							Day, Year)
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	30. Neme and address of person	on who co	empleted cause of	death (Item 23	3a) (Type,	Print)								ND 21287
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State		2000	Dere	1	O.	100	uks)	/						



State of Maryland / Department of Health and Mental Hygiene

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4a Facility Neme (If not Institution	larris Hel	man						2. Dete of Dee	th Dey (	Yaer	. Time of Death
4a Facility Neme (If not Institution		man					16	YICKER	2011		
					-		1	March	24	2000	12:50
					4	b. City, To	wn, or Loca	ation of Death	4c. County	y of Deeth	
Washington Co						Hage	stown			hington	
5. Sociel Security Number	6. Sex 7	. Age (In yrs.	last birthday, Yrs.	Months Months	r 1 Year Deys	if Under Hours	Min.	B. Dete of Birth (Month, Day	Year)		(Stete or Fore
207-03-5042 Usuel Residence of Decedent		89	113.					Oct. 20	, 1910	Pennsy	lvania
10a. Stete 10b. Count	,	10c. Cit	y, Town or L	ocation						10d.	Inside City Lim
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	igton	H	agerst		. Code				On Citizen of	What Country?	X
	oo Drivo										
		ent Evar in U	S 13			ispanic Or	loin? (Spec	ify Yes or No-			ndian.
The second secon	Armed Ford	es?		If Yes, spe	cify Cuba	in, Mexical	n, Puerto Ri	ican, etc.)			
	If Yes, Giva			1 Tes	2 No	Specify:			Specify: White		
15. Decede	nt's Education		16a. Dece	dent's Usu	el Occup	etion			16b. Kind of B	Susiness/Indust	ry
		(or 5.)	(Give	DO NOT u	ork done i ise retirec	during mos d)	t of working				
8	College (1-s	+01 3+)	E	lectr	icia	in			Priva	te Indu	stry
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Emory David	Helman					Can	coline	Spren	kle		
19e. Informent's Neme/Reletion	ship (Type, Print)		19b. Mail	ing Addres	s (Street	and Numb	er or Rural	Route Numbe	r, City or Town	, State, Zip Co	de)
Clara V Hel	man		135	21 Pa	radi	se Di	rive F	Jagerst	own M	2174	2
20e. Method of Disposition	IIIaII	1001	Dete								
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				1			-				
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27. Menner of Deeth Neturel 5 Pending invastigation 3 Suicide 4 Homlcide 4 Homlcide 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work?  28c. Neturel 5 Pending invastigation 28c. Injury at Work? 1 Yes 2 N  28e. Plece of Injury - At home, ferm, street, factory, office							□ No  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and											
29b. Signature and title of certifi	ar			29	c. Licans	e number			29d. Date sign	ed (Month, Day	r, Year)
•	XXXX	<b>&gt;</b> ·			N	F 3	10	,	2000	0 22	2000
(	10.00				0	5 3	548	)	11 lare	n 11,	2000
20 Nome and address of	salan nametra e de la compansión de la c	and other water was	- 000	Challes 1							
30. Neme and eddress of person	who completed cause	of deeth (Item	n 23a) (Type	, Print)	00	Λ	[1		۸ ۱	3,31	,
	10. Street and Number  13521 Paradi  11. Meritel Stetus  1 Never Merried 2 Merited  3 Widowed 4 Divorced  15. Deceder (Specify only highe Elementery/Secondary (0-12)  8  17. Father's Name (First, Middla, Emory David  19e. Informent's Neme/Reletion  Clara V. Hell  20e. Method of Disposition  1 Burial 2 Cremetion  4 Donetton 5 Other (3)  21. Signeture of Fuheral Sarvice  23a Pertl. Enter the disease, on shock, or haert feliure. Lis  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or influry that initiated events rasulting in death) Last  Pert It. Other eignificant conditions  25. Wes case referred to medical substantial invast as a substantial of the condition of the cause of	13521 Paradise Drive  11. Meritel Stetua  1 Never Merried 2 Merried  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest greda completed)  Elementery/Secondary (0-12)  College (1-2)  17. Father's Name (First, Middla, Last)  Emory David Helman  19e. Informent's Neme/Reletionship (Type, Print)  Clara V. Helman  20e. Melhod of Disposition  1 Burial 2 Cremetion 3 Ramoval from Stanck, or haert feilure. List only own flausa on eer shock, or haert feilure. List only own flausa on eer shock, or haert feilure. List only own flausa on eer shock, or haert feilure in the disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in death) Last  25. Wes case referred to medical examiner?  1 Yas 2 No  27. Menner of Purchast Conditions contributing to death death of Could not be determined to building invastigation  28. Pert It. Other elgnificant conditions contributing to death determined 28e. Plece of building check only 2 Medical Examiner: On the base of the property of	13521 Paradise Drive	10e. Street and Number  13521 Paradise Drive  11. Meritel Stetua  1□ Never Merried 2 Merried  3□ Widowed 4□ Divorced  11. Decedent's Education (Specify only highest greds completed)  12. Decedent's Education (Specify only highest greds completed)  13. Decedent's Education (Specify only highest greds completed)  14. Pather's Name (First, Middla, Last)  15. Decedent's Education (Specify)  16. Decedent's Education (Giville)  17. Father's Name (First, Middla, Last)  18. Informent's Neme/Reletionship (Type, Print)  19. Mail  19. Informent's Neme/Reletionship (Type, Print)  19. Mail  20. Method of Disposition 1	10. Street and Number	106. Street and Number  13521 Paradise Drive  11. Meritel Stetue  11. Meritel Stetue  12. Wes Decedent Evar in U.S. Armed Forces? 12. Wes Cover of Peters 12. Wes Decedent Evar in U.S. Armed Forces? 12. Wes Cover of Peters 13. Wes Decedent St. St. Step of Peters 14. Step of Peters 15. Decedent's Education (Specify only highest preda completed)  Elementery/Secondary (0-12)  Elementery/Secondary (0-12)  Elementery/Secondary (0-12)  Emory David Helman  19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street 13521 Paradin 1	10. Street and Number 13521 Paradise Drive 11. Merited Stetus 1 Nerver Merried 2 Merried 3 Widowed 4 Droroced 12. Wes Dependent Evar in U.S. 13. Was Dependent of Hisparic Or Yes, specify Cubban. Merical 11. Yes 2 Mo Specify 12. Wes Dependent Evar in U.S. 13. Was Dependent of Hisparic Or Yes on Investigation (Investigation of Head Septiment Properties) 15. Dependent Evar in U.S. 16. Dependent's Septiment Or Septi	10. Street and Number  13521 Paradise Drive  11. Meritet Stetus  12. Meritet Great Great Complete  12. Meritet Great Gre	10. Zie Code   1. 3521 Paradise Drive   1. 3522 Paradise   1. 3522 Paradise	10e. Street and Number   10f. Zip Code   10g. Chitzen of   121742   10g. Chitzen of   121742   11l. Martial Status   12   West Decodent Strain U.S.   13   Was Decodent of Hispanic Origin? (Specify Yes or No-mark Forces?)   14. Re   17   17   18   17   18   18   18   18	19. Street and Number   19.



#### Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Day Yaar **Physician** CHARLES ROBERT HARVEY March 24 (da)3 2000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) SEPT. 7,1919 5. Sociel Security Number 9. Birthplace (Stata or Foreign Deys 1X M 2□ F MARYLAND 218-07-7296 80 Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYas 2 No Directo MARYLAND DORCHESTER HURLOCK 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 108 MARYLAND AVENUE 21643 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No 1942-If Yes, Give 1 Nevar Married 2 N Merried 1 Yes 2 No Specify f Yes, Give Year or Datas: Specify: à 3 ☐ Widowed 4 ☐ Divorced 1945 WHITE Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) PLANT SUPERVISOR MANUFACTURING 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be CLARENCE BENJAMIN HARVEY MARY ELIZABETH PHILLIPS 19e. Intorment's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ANNA LOUISE HARVEY/WIFE P. O. BOX 212, HURLOCK, MARYLAND 21643 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Buriel 2 □ Cremetion 3 □ Removet from State MARYLAND VETERANS CEM. 3/28/00 4 ☐ Donetion 5 ☐ Other (Specify) BEULAH, MARYLAND 21. Signeture of Funeral Service Lig 22. Name end Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET, MD 21631 Part L Enter the diseesa, or computations that shock, or heart teilure. List only one cause of musad the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) · Otherosclerotic Cardiovascular Disease Physician/Medical Examiner Fibrillation Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of) thet initiated events resulting In death) Last Due to (or es e consequence ot) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by

**Physician** /Medical Examiner

**Funeral** 

Director

Maryland 21215-0020

altimore,

218-07-7296

harts Harrey

filed within

Pages 1 and 2 should be

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The law requires that the death certificate be executed use as the bunal-tre P.O. Box 68760, signed by the a Division of Vital Records, been certificate Attending Physician: Medical Certification: To spital or Attending Physhours after death.

neral Director: After this y filled in by the funeral director. this To the Hospital within 24 hours a To the Funeral C completely filled

							Α,
					р	Vas an autopsy erformed?	24b. Were eutopsy findings available prior to completion of cause of death?  1  Yas 2 No
25. Wes case reterred to medical				26. Place of	Deeth (Check or	nly one)	
examiner?	Hospitel: 1 Inpatient 2	ER/Outpatient 3	DOA	Other: 4 Nursir	g Home 5 🗆 R	Residence 6 Oth	ner (Specify)
27. Menner of Deeth  1 Neturet 5 Pending 2 Accident Investigation		28b. Time of Injury		Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Descri	ibe how injury occur	red
3 Suicide 6 Could not b 4 Homicide determined		nome, term, street, to	actory, o	office		on (Street and Numb Town, State)	per or Rural Route Number,
29a. Certifier (Check only one) 1X Certifying Ph	ysician: To the best of my known income control of the best of examination and manner stated.	owledge, deeth occu etion end/or investig	irred at a	the time, date end p my opinion, deeth o	ece, end due to courred et the tir	the cause(s) and mome, date end place,	enner es stated. and due to the cause(s)
29b. Signeture end title of certifier	()		29c. L	icense number		29d. Date signe	d (Month, Dey, Year)

State Registrar

nanonne 31. Data filed (Month, Dey, Year)

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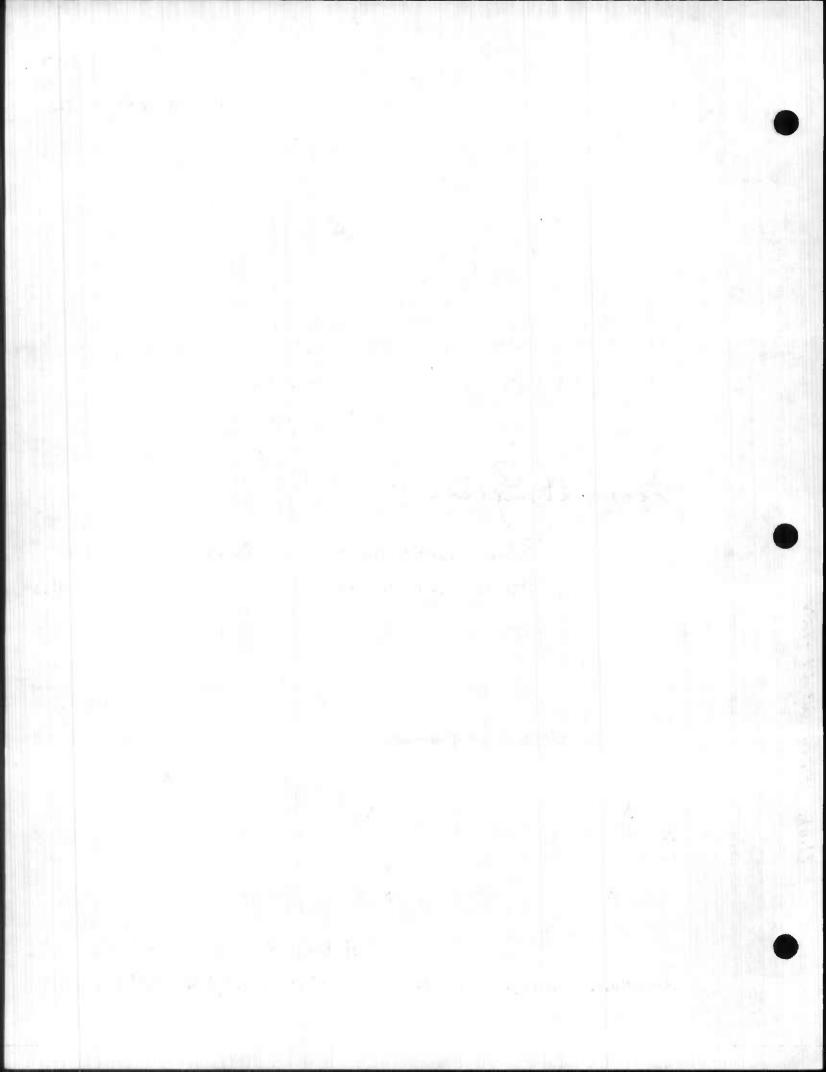
30. Nama and address of person wno completed ceuse ot deeth (Item 23a) (Type, Print)

D.D. 100 8 32. Registrar's Signeture zener

100 E. Carroll 84. Salisbury, MD 21801

3-27-00

**DHMH 16 Rev 6/95** 



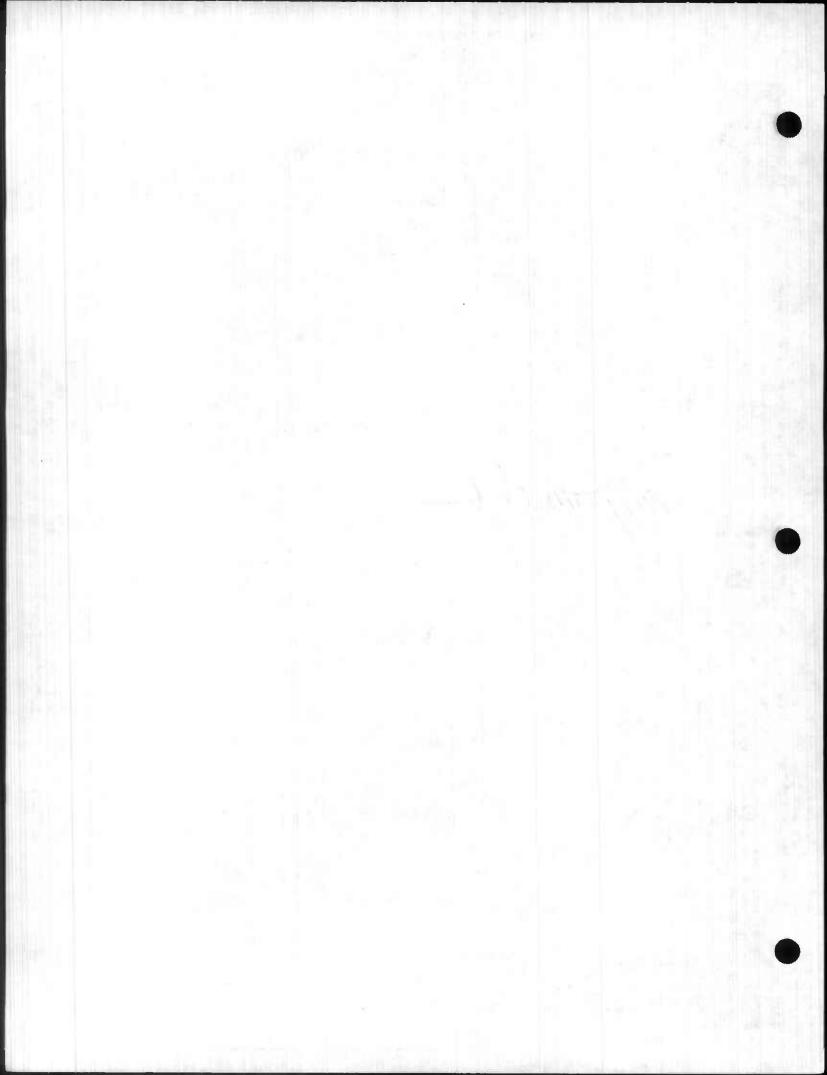
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Certificate of Death	Reg. No.	00		15	0	(

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		<b>D</b>		Decedent's Nan	ne (First, Middla, Las	ot)						2. Dete of D Month		Year	3. Time of Deeth		
	4.	Physiciar /Medica	1		ille		narles		Η.	AYS,		marc	h Z	1 2000	p 1354		
	1	Examine	4a		(If not institution, give						4b. City, Town, or L			nty of Death			
		•		Wash i I	ngton Cour		ital Age (In yrs.	hat histha	face) If Under	er 1 Year	Hagerstow If Under 24 Hrs.			INGTO			
		Funeral Director	21	14-16-24	473	M 2□ F	83	Yrs	Months			8. Date of B (Month, D	ey, Year) 3,1917	Penn	place (Stata or Foreign ofry) ISY I Van ia		
		show		10a. Stete 10b. County 10c. City, Town or Location											Od. Inside City Limits		
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		with the	100	10e. Street and Number 10f. Zlp Code 10g. Citizen of V									f What Coun	itry?			
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57	5-0	72 ho	- Completed	(Spe	15. Decedent's Ed		16a. De	ecedent's Us Siva kind of w	lent's Usual Occupation kind of work dona during most of working DO NOT usa retired)			16b. Kind of I		dustry			
	121	ne.	1	Elementery/Sec		or 5+)						Note:					
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714	ary	should and Mer marke surratio			Name/Relationship (7			1		ss (Stree	t and Number or Ru	ral Routa Num					
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	Ē	Peg ent nt: h			Cremation 3 5 Other (Specify		Gre	enlawr	n Memori	ial Pa	ark March 3	30, 2000	William	sport	, MD 21795		
	Baitimore,	Departm Departm Importa any inju	21.	. Signeture	Service UNA	27 1	/		0SR0R	and Addre	ess of Facility UNERAL HO	MF			Y - WEN		
		80 = 9		P.O.Box # 348 Williamsport, MD 21795-0348													
			23	a. Part1. Enter shock, or ha	the disease, or comp failure. List only	olications that cau	sed the deat h line.	th. Do not	t enter the mo	ode of dyi	ing, such as cardiac	or respiratory	errest,		Approximete Interval Between		
	7	Physician / /Medical / Examiner	dis	Immediate Cause (Final disease or condition resulting in deeth)  a Ventricular Tach year dia 10 min													
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	P.O.	that the ded by the a detached!	Par	t II. Other algni	ificant conditions co	ontributing to deat	h but not res	sulting in th	he underlying	cause g	ven in Part I.		~/		o the cause of death?		
	9	that ned b	_		Jastroe	sophas	eal	Ket	UX	Dis	lest	11	Yes 200N	o 3 Pro	oubly 4 Onknow		
45	scords	The law requires that the deeth certificate be sate has been signed by the attending physicial page 2 should be detached for use as the bur											s an autopsy formed?	av	fere autopsy findings vallable prior to ompletion of cause death?		
Hays	- B	elclan: The law certificate has t irector, page 2 s	5									10	Yes 200	11	☐ Yes 2☐ No		
	/ita	yalclan: s certifica director,		Was case refe	erred to medical						26. Plece of Dea	th (Check only	one)				
onille	of V	A SE P	2	1□ Yes 2	NO	Hospital: 1 Inp		ER/Outpo		DUA			sidenca 8 🗆		fy)		
2	n o	After thi funerel	27.	27. Manper of Death 1 Netural 5 □ Pending 28a. Date of Injury 28b. Time of lnjury at Work? 28b. Injury at Work?													
0	Division of Vital Records,	or Attending Physician: filer death. Director: After this cartifical in by the funerel director.		2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)										al Routa Number,			
		To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Affert completely filled in by the funeral Balantical Confessions.	29	a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	yelcian: To the be iner: On the basi and manne	s of examina	owledga, d	leath occurre or investigation	d at the to	ime, date and placa opinion, death occu	, and due to th rred at the time	e cause(s) and e, date and place	manner as s a, and due t	stated. to the cause(s)		
		within To the complete of the		29b. Signeture and title of capitler 29d. Date sign										ned (Month,	ned (Month, Day, Year)		
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			30.	Name and add	lress of person who	completed cause	of death (Iter	m 23e) (Ty	rpe, Print)			~ .					
				15	n- Cico		3	B	uski	t.	Dr. h	Illian	sport	Md			
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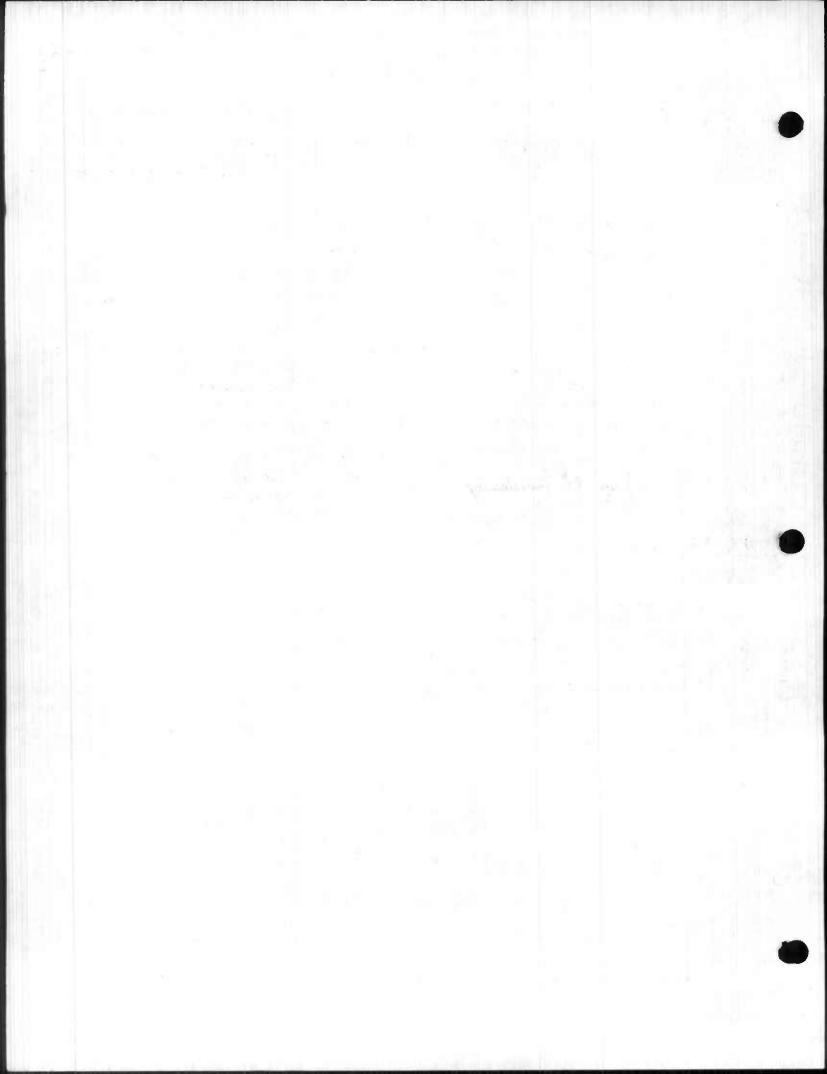
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State of Maryland / Department of Health and Mental Hygiene 00 11589

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Physician		1. Decedent's Name (Fig.									ate of Dee	th Day	Year	3. Time of Death		
/Medical	1	CHARLES		DWARD HARNE, JR							AR	27 6	2000	Sobu		
Examiner		4a. Facility Neme (If not	e (If not institution, give street end number)  4b. City, Town, or Lo									th 4c. County of Death				
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uneral		5. Social Security Number		711 005		last birthday	) If Unde Months	or 1 Year Days	Hours	Min (M	ite of Birth Jonth, Day	Year)	9. Birthple	ece (State or Foreign		
ector	-	173-03-16 Usual Residence of Dec	-	ζ	87	Yrs.				Mar	ch 1	, 1913	Wayne	sboro, PA		
	- 1-		. County		10c. Cit	y, Town or I	ocation						10	d. Inside City Limits		
al', or items 23a or 28a-f show Examinet must be notified at by Funeral Director	5	MD Washington Boonsboro												1 ☐ Yes 2 ☐ No		
E P	3	10e. Street end Number	asiiitiigu	OH	DOOL	ISDOLC		ip Code				10g. Citizen of What Country?				
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ing must be notined.		11. Maritel Status	SATTLE							n? (Specify V	es or No-		e - America	n Indian		
Ē	3	Armed Forces?  1 Never Married 2 Married I Yes 2 No If Yes, specify Cube I Yes, Sive I Yes												ck, White, etc.		
à		3 X Widowed 4 □	Divorced	1 ☐ Yes	2 XNo	Specify:			Specif	Whi	te					
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5		12	, (0 .2)		Machinist Fe							Gederal Government				
0		17. Father's Name (First,	, Middle, Last)					18. Mother's Name (F		, Middle, I	Ma <i>lden Suma</i> n	19)				
2 2		Charles H	E. Harn	е					Vall	lye A.	Izer					
raumatic ev		19a. Informant's Name/F	Relationship (T)	ype, Print)		19b. Mai	ing Addres	s (Street	and Number	or Rural Rout	e Number	, City or Town,	State, Zip (	Code)		
Ner traumatic event, tre Me To Be Compi		Nancy Roach	n I	Daughter		6355	Lori	ing [	OR Co	lumbia	a MD	21045	5			
r other	1	20a. Method of Disposition 1		Dames of from Chair		lace of Disp emetery, cre	osition (Na	me of other place	ce)	Date	9	20c. Location -	City or Tow	m, State		
		4 Donation 5			Gr	een H	ill C	emet	ery	Marc	h31 V	<i>l</i> aynesb	oro	PA 17268		
any injury or ot		21. Signature of Auneral	Service Licens		1	2	2. Name a	nd Addre	ss of Facility			uneral Home, Inc.				
E 0		James A	. Bower	SOX	of	5	O S B	road	ST W	aynesb			268			
ian icai		23a. Part1. Enter the dis shock, or heart tails Immediate Cause (Final disease or condition	ure. List only of	icetions that cause ne cause on each	line.	n. Do not er		de ot dyir	ng, such es ca	ardiac or respi	iratory arr	est,	2	Approximate Interval Between Onset end Deeth		
miner		resulting in death)	14	a		r as a conse							1.3	- 11 gs		
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V Q	-											completion of death?				
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rector, pag	1	5. Was case reterred to examiner?	medical						26. Place of	Death (Chec	ck only on	e)				
2		1 Yes 2 No	H	lospital: 1 ☐ Inpati	ient 2 🗆 I	ER/Outpatie	nt 3 D0	OA Oth	er: 4 4 Nursi	Ing Home 5	Reside	nce 6 DOth	er (Specify)			
on:	2	7. Manner of Death	Pending	28a. Date of Inj (Month, Di	ury ay Year)	28b. Time o	t 2	28c. injun Worl			28d. Describe how Injury occur					
led in by the funera Certification:		2 Accident	Investigation	(Monar, Day 16ar)			М		Yes 2 □ No							
T = 0		3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)								28t. Loc	28t. Location (Street and Number or Rural Route Number, City or Town, State)					
0	L	and the point									ony or romi, state,					
within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	2		ertifying Phys	iclan: To the best	ot my know	viedge, deat	h occurred	at the tim	ne, date and p	place, and due	to the ca	tuse(s) and ma	nner as stat	ted.		
Med Med	-	one) and manner stated.									io timo, di	late and place, and due to the cause(s)				
100	2	29b. Signeture and title of certifier 2							29c. License number				29d. Date signed (Month, Day, Year)			
		D 18019									MARCH 27, 2000					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VASANT DATTA, MD 334 MILL ST HALERSTOWN, MD 21															
	-	VASANT I		`		MI	LLS	て	MAL	ERST	OW	v, m	0 21	740		
State	3	1. Date filed (Month, Day	-		rar's Signat	ure		/								
Registrar		MAR	31 200	JU JU	neva		A	park	2							
						-	-									



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth AMonth D111 HESSEY 2:10 AM ITGINIA 2000 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth REHABILITATION Asa In use last birthdey) If Undar 1 Year Denton NUTSING MOLINE If Under 24 Hrs. Hours Min. 8. Dete of Birth Month, Day, 5. Sociel Security Number 6. Sax Birthplece (State or Foreign Country) Months Deys 1□M 2▼F Yrs. 20-09-1590 MD JUNE 5,1911 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 Yes 2 No MD CAROLINE FEOETALS BUYO 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 6320 NOBLE ROAD 21632 USA Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) Was Decedant Ever In U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: 1 □ Navar Marriad 2 □ Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) RETAIL - CLERK FOOD SerVICE 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) ELVA TUCKEY AYTEY MAE STANT 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5821 NOBIE FEDERALSBURG, MD JEAN MORRIS - DAUGHTEY RD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cramation 3 Removel from Stete 4 Donetion 5 Other (Specify) FEOTIALSBURG, MD 22. Name end Address of Fecility WILLIAMSCW 21. Signature of Funeral Service Licensee 2N624 HOME FEDERALSBURG. 21632 MD 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each lina. Approximete Intervel Batwe Onsat end Daath Immadiete Cause (Fine) Sepsis disaasa or condition resulting in deeth) Due to (or es e consequence of): nc Sequentially list conditions, if any, leading to Immediate ceusa. Entar Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Lest Dua to (or as a consequence of): Vasculen Disease Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yss 2 No 3 Probably 24b. Were autopsy findings availabla prior to 24a. Was an autopsy performed? complation of causa of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axeminar? 26. Placa of Death (Check only one)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mantel Hygiene. Important: if item 27 is merked other than "natural", or items 28s any injury or other traumatic avant

Baltimore, Maryland 21215-0020

tha Meryland

Examiner Physiclan/Medical by Completed Be 0 Certification:

siclan and buriel-transit physician s the buriel 90 98 usa ata hes been signed by that page 2 should be deteched this cartificata hes To the Hospital or Attending Physician: within 24 hours eftar death.

To the Funeral Director: Aftar this cartifica funaral filled in by

Records, P.O. Box 68760

Division of Vital

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 20 No 1 Yes 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how Injury occurred 28b. Time of

1 Naturel 5 Pending Investigation 2 Accidant 6 Could not be determined 3 ☐ Sulcide

4 Homicide

29b. Signeture and title of certifier

1 ☐ Yas 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

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29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Creath (Item 23e) (Type, Print) 30. Name end eddress of person who completed ceuse

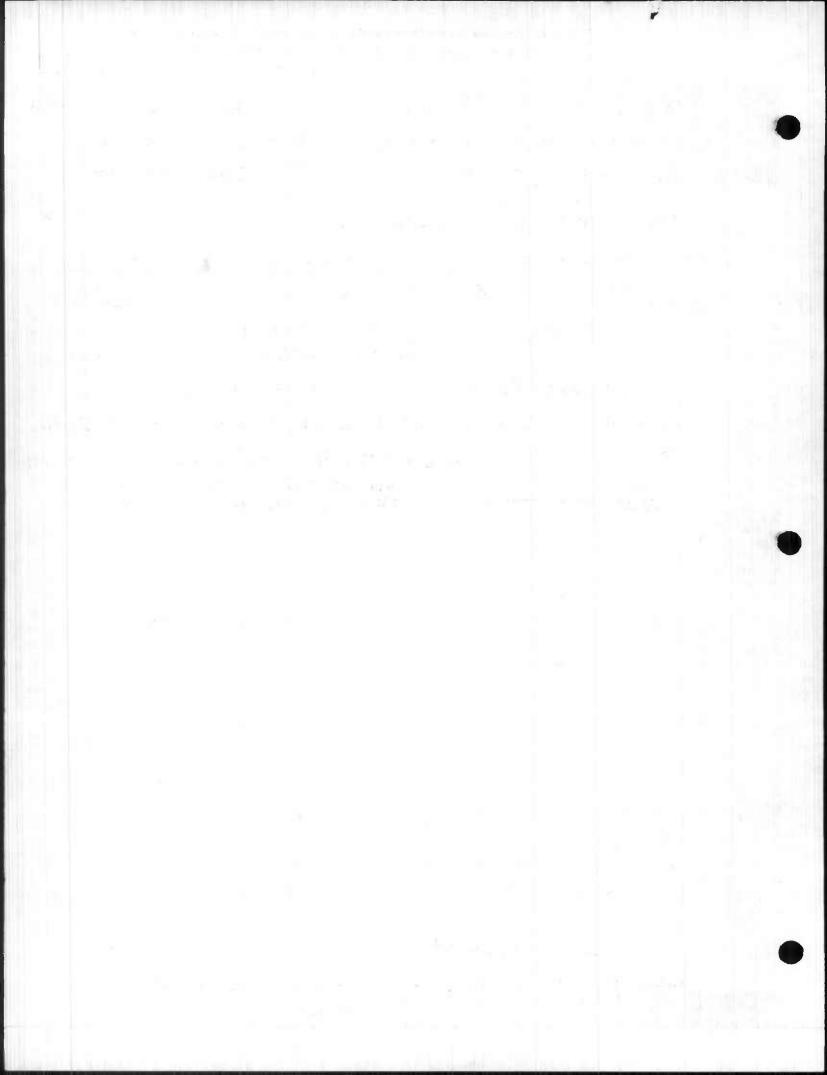
MOFFETT PO.BOX 31. Dete filed (Mon A) 32. Registrar's Signature

TON, MA

State Registrar

complataly

Medical



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Physician Month Evelyn Elizabeth Harbaugh 24, 2000 March 10:25 PM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 13444 Clopper Road Hagerstown Washington # Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey Year) 9. Birthplece (State or For Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (Stete or Foreign **Funeral** 1□M 2□F 242-18-4291 80 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or Items 23s or 28s-f show traumstic avent, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13908 Weaver Avenue Box 223 21767 USA permit. Pages 1 and 2 should be filed within 72 hours after death to Copentry or Health end Montal Hygiene. Important: If Illum 27 is marked other than "netural", or Health any injury or other traumation. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plastic Fabrication 8 Fairchild Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Tom Sledge Neoma Mae Holder 19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) William L. Harbaugh Husband 13908 Weaver Avenue Box 223 Maugansville, Md. 21767 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Rest Haven Cemetery 3/28/00 | Hagerstown, Maryland ture of Funeral Service License Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Physician/Medical 2 Due to (or as a consequence of) for use as signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Wara autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: Nethin 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director, p 25. Was casa reterred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 COther (Specify) Daughter Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Home 1 Natural 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar es stated.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

edied Commi

State Registrar 29b. Signature and title of certifie

31. Date tiled (Month, Day, Year)

MAR 2 7 2000

and address of parson who complated cause of death (Itam 23a) (Type, Print)

ARC

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32. Registrar's Signature

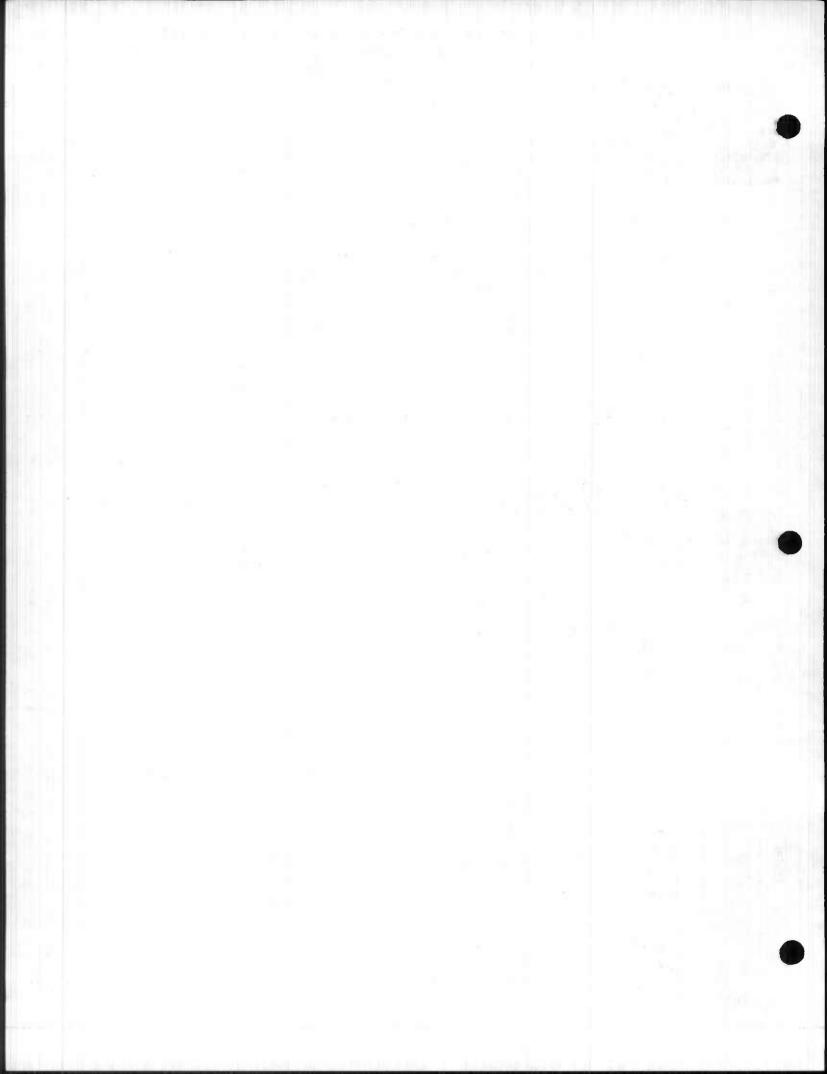
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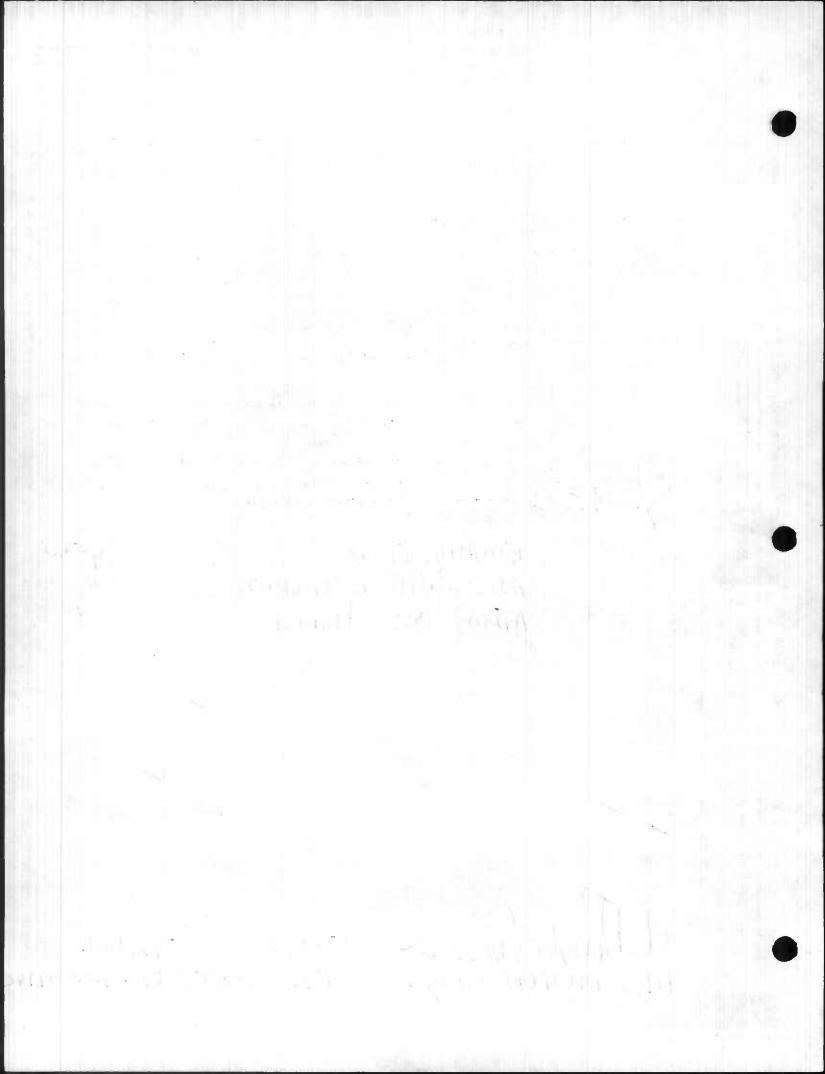
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Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene 00 11592

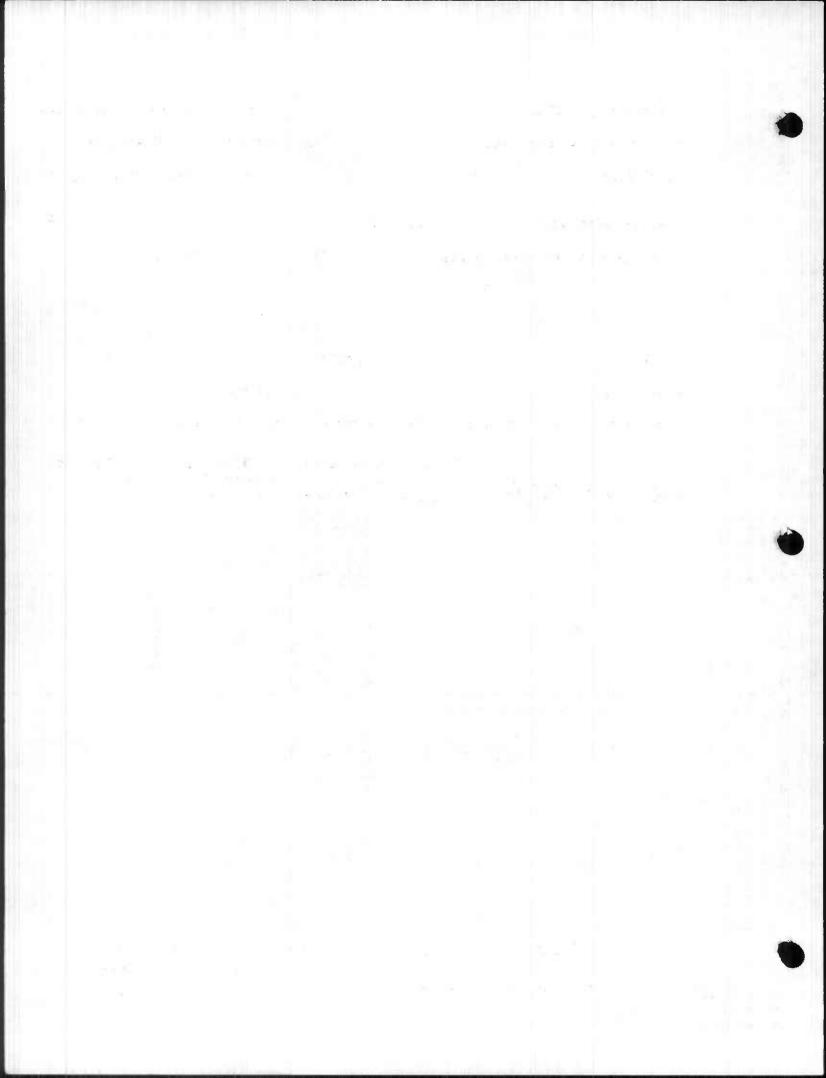
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		10900 Allen Ave	nue				Hagers	town	Washi	ngton
Funeral		5. Social Security Number 6.	Sex 7. /	Age (In yrs. las	st birthday)	If Under 1 Yes	ar   If Under 24			9. Birthplace (State or Fore Country)
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 594 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Dete of Death Day **Physician** Month Year MARGARET M: 1 bouens HENRIETTA 0925 JONES 22 march 2000 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 K 214-32-1326 66 Yrs. MD Director 05-14-Usual Residence of Decedent 10a. Steta 10b. Count 10c. City, Town or Location 10d. Inside City Limits show WESTONER OMERSET 1 Yas 2 No Funeral Director - 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 9908 21871 + Airmoun I KD 12. Wes Decedent Evar in U.S. Armed Forces? Barnel 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Maritel Stetus Bleck, White, etc. hours after Yes 2 No 1 Nevar Married 20 Merried 214-32-1326 1 ☐ Yes 2 KNo Specify þ KlACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within ntery/Secondery (0-12) College (1-4or 5+) tactory ADORER Baltimore, Maryland Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, 2p Code) Howard M: IbournE 2 J ess€ 19e. Informent's Neme/Reletionship (Type, Print) × Dopartment of Health a Important: If Item 27 is any injury or other tra NEIDA Fairmount RD Westover 21871 EAGLE S:STER MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 4 Donetion 5 Other (Specify) United Church Competer 3.27-08 WES 21. Signature of Funeral Service Licensee 22. Name and Address of Fedrity Anthony E. Ward Funeral Horn 30639 Hampdon Am. Princess Anne, 23a. Part 1. Enter the disease, or complications that caused that deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part 1. Enter the disease, or complications that caused that deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete WESTOVER 21853 Approximate Intervel Between Onset end Death Physician Immediate Cause (Finel diseasa or condition resulting in deeth) /Medical 6 MM **Examiner** Due to (or es e consequence of). Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Sequentielly list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last pug Due to (or es a consequence of): P.O. Box 68760, Dua to (or as a consequence of): Marcaret for use as is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ZX No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 1 □ Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this illed in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred After 5 Pending investigation 1 Waturel death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicida 6 Could not be determined 28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier Sompletely To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 20507 GU 30. Nama and address of person, who completed cause of deeth (Item 23a) (Type, Print) ARROLL St. SHUSBURY Joseph MASSO 45 31. Dete liled (Month, Dey, Year) 32. Registrer's Signetura

**DHMH 16 Rev 6/95** 

State Registrar

MAR 2 7 2000

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11595 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death 10:05 AM marc Claude William KARN 27 2000 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) March 29, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign Months Days Hours 1⊠ M 2□ F Yrs. 219-14-8187 75 1924 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Washington Maryland Hagerstown 10e. Street end Number 10g. Citizen of Whet Country? 1042 South Potomac Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ⊠ Yes 2 □ No If Yes, Give WW II Yeer or Detes: WW II 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 deputy chief city fire department 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Leroy Karn Sr. Clara Helen Hockman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Ruth Karn - wife 1042 South Potomac Street, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Cedar Lawn Memorial Park 3/30/00 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es a consequence of) Due to (or as e consequence of)

**Physician** /Medical Examiner

The law requires that the death certificate be assecuted

Division of Vital

paga 2 should be

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this cartifica complataly filled in by the funeral director;

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

ms 23a or death with

"natural", or

permit. Pagas 1 and 2 should be filed within 72 ht. Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "nature eny injury or other treumatic event, the Wed called.

filed within 72 hours aftar

Maryland

Baltimore,

am

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Winknown 1 Yes 2 No artem deresse p Be Completed store heart falus 24b. Were eutopsy findings evellable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2⊠No 28a. Dete of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Neturel 1 Yes 2 No 2 Accident investigetion 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es stated.

(Check only one)

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of partifier

0 00 46940

29d. Date signed (Month, Day, Year) 28/2000

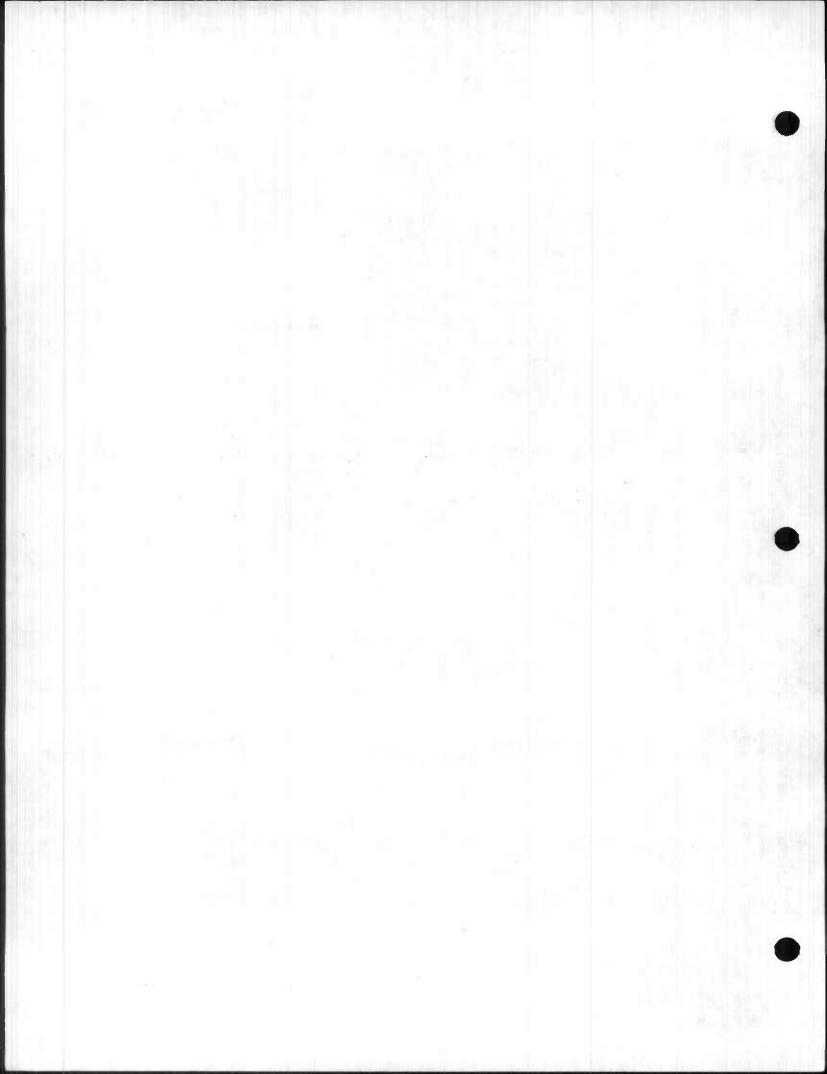
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

KUTZERA. MD

State Registrar

31. Dete filed (Month, Dey, Year) MAR 2 9 2000

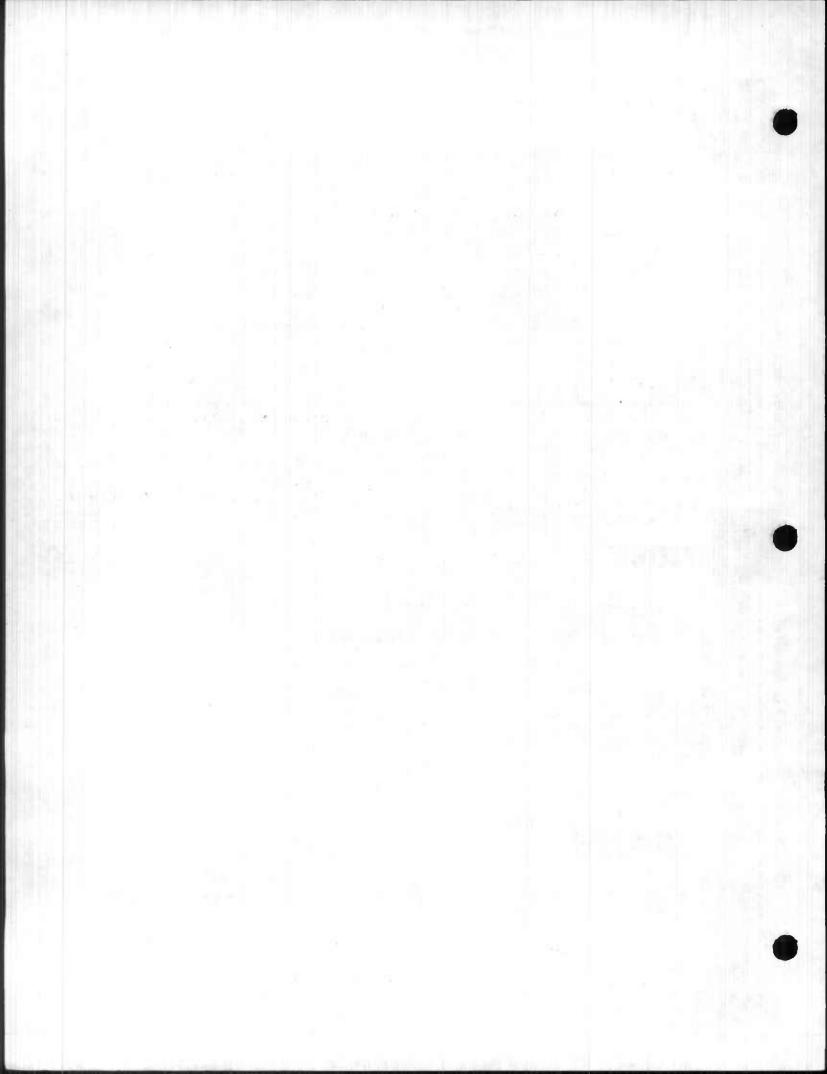
32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

				Ce	ertificate o	of Death	R	leg. No.	11596
Dhyeie	ion	1. Decedent'a Nama (First, Middle, Last	1				2. Data of Dea Month	th Dey Ye	3. Tima of Death
Physic /Medi		Donald Charles L					March	24, 2000	1620
Exami	ner	4a Facility Nama (If not institution, give				4b. City, Town, or		4c. County of D	
3-		14109 Stonebridg  5. Social Security Number 6. Se		(In yrs. last birthday	If Under 1 Ye	1	sville	1	gton County
Funeral Director			XM 2□ F	61 Yrs.	Months Da			1,1938	Birthplace (Steta or Foraign Country) Pennsylvania
Aland Aland		10a. Stata 10b. County	1	IOc. City, Town or L	ocation				10d. Insida City Limits
Man	to	MD Washingt	on Co.	Maugansv	ville				1 ☐ Yas 2 No
ith with the Marylar 23a or 28a-f show	al Director	10e. Street and Number 14109 Stonebridg	e Lane		10f. Zip Code	21767	1	0g. Citizen of What	
20 after des or flems	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas:	er in U,S. 13. 1/16/57 1/15/63	Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Maxican, Puarl No Specify:	specify Yes or No- to Rican, atc.)		Amarican Indian, Vhita, atc. White
72 hours	etec	15. Decedent's Edu (Specify only highast grad		16a. Dece (Giv.	edent's Usual Oci a kind of work do	cupation na during most of wo ired)	rking	16b. Kind of Busins	iss/Industry
within then the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		tomotive			State Go	vernment
		12 17. Father's Name (First, Middle, Last)	0				ma (First, Middle,		
yian Suld be Mental Briked o	To Be	Charles Lucas				Grace :	Fensterm	acher	
Mar d 2 sh th and 7 la m traum		19a. Informant's Name/Reletionship (7) Shirley Lucas/Wit				eet and Number or Ru ebridge Lai			te, Zip Code) aryland 21767
Baltimore, semit. Pages 1 an Separtment of Hasil myorlant: If New 2 my injury or other Mag.		20a. Mathod of Disposition  1 Burial 2 Gremation 3 F  4 Donation 5 Other (Specify)			osition (Nama of amatory or other p urg Cren	place)	Data Mar.27	20c. Location - City Smithsbu	or Town, State
Baltim permit. Pa Department Important any injury page.		21. Signature of Funeral Service Licens	98	2	2. Nama and Add	drass of Facility A. Fiery	Funeral I	Home M	aryland 21742
		23a Fart1. Enter the dississe, or complete shock, or heart failtire. List only o	ications that caused th						Approximata
Physician /Medical Examiner	ner	Immediata Causa (Final disease or condition resulting in death)	net.	MON 8	mall c	4.4	ny cen		friterval Between Onsaf and Death
68760, tiflcata be axecuted g physician and as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Di	ue to (or as a conse	equence of):				
E 24	Medical	resulting in death) Last	Du	e fo (or as a conse	quence of):	La H	35.7		
death cert death cert a attendin	lan								
the de constant	Physician/	Part II. Other significant conditions con	ntributing to death but r	not resulting in tha	underlying causa	givan in Part I.			outs to the cause of death?
o tatt	è						050	es 2 No 3	Probably 4 Unknown
aw requir	Completed						24a. Was a perfor		4b. Wera autopsy findings available prior fo complation of cause of death?
_ F = a	Con						1 🗆 Y	as 2 No	1 Yes 2 No
yelclen: The	8	25. Was case refarred to medical axaminer?	4 4 - 4				ath (Check only or	18)	
# # P O	2	1 Yes 2 No	lospitat:	2 ER/Outpatie	AIL SEL DOM		-	ence 8 Other (S	Specify)
DIVISION  I or Attending P  after death.  Director: After  I in by the funer	atlon	27. Manner of Death  1 Naturat 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (fnjury	V	njury at Vork? □ Yas 2 □ No	28d. Dascribe h	ow injury occurred	
DIVIS	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At homa, farm, s (Specify)	treet, fectory, offic	Ce	28f. Location (S City or Town		r Rural Routa Number,
DIVISION To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	nician: To the best of n ner: On the basis of ex and manner stete	camination and/or it	th occurred at the nvestigation, in m	time, dete end place y opinion, daath occu	e, end due to the curred at the tima, d	ause(s) and manna ate end place, and	r as stated. dua to the causa(s)
To the Took	Σ	29b. Signature and title of certifier			29c. Lica	ansa number	. 2	9d. Data signed (M	onth, Day, Year)
_	_	17Ah	= MD		1	4818	4	3/27/	00
		30. Nama and address of person who co			Print)	つ坊 st	nest P.	reduice	00 MD 21701
Sta Registr		31. Data filed (Month, Day, Year) MAR 2 8 2000	32. Régistrar's	Signatura &.	don	61			

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 0214 ROBERT EUGENE LOHMAN 30 2000 March 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 15 M 2 F Months Days 84 189-52-9344 11, 1915 Shady Grove, PA Usual Rasidenca of Decedan 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10431 Crystal Falls DR 21740 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. 1 X Navar Married 2 Married 1 ☐ Yes 2 ☑ No Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Carrier Newspaper 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Jacob Pentz Lohman Addie Bell Funk 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Addie J. O'Connor Niece 10431 Crystal Falls DR Hagerstown 21740 MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1X Buriai 2 ☐ Cramation 3 Nemoval from State Washington Township 4 ☐ Donation 5 ☐ Othar (Specify) Price's Church cemetery Apr 3 Franklin County, PA 22. Nama and Addrass of Facility Grove Funeral Home, Inc. 21. Signature of Funarat Service Licensea amesel 50 S Broad ST Waynesboro PA James A. Bowersox Soulerse 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Approximata Intarval Batween Onsal and Death trimediata Causa (Final disaasa or condition rasulting In daath) Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Norne 23a or

8

'natural'.

the Medical

72 hours after

filled within

Montal marked

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Lepartment of Health a Important: If flem 27 is any Injury ---Pages 1 and 2 mart of Health

Baltimore, Maryland 21215-0020

Johnan, Robert Eugene

Examiner must be notified at

Director

Funeral

PV

Completed

Be

Physician/Medical Examiner as the burial-tran and attending physician 080 the page 2 should be detached signed by Completed by certificate has Be nours after death.

neral Director: After this ce
y filled in by the funeral dire Certification: To

25. Was casa ratarred to medical examinar?

31. Date tiled (Month, Day, Year) MAR 3 1 2000

5 Panding Invastigation

6 Could not be

1 Yas

27. Manne of Death

2 Accident

3 Suicida

29a. Cartifier

4 Homicida

(Check only onel

The law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital

Physician:

Hospital or Attending

within 24 hours

completely

1	1 -1 = 5
·Ac	upe respiratory tacture
. B.	ere 3 letter melliname
	Dua to (or as a consequence of):
C	Dua to (or as a consaquanca ot):
d	

28c. Injury at

29c. Licansa number

1 Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Inpatient

Date of Injury (Month, Day Year)

Hospital:

23b. Did tobacco use coptribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy performed? Wara autopsy findings available prior to complation of causa of death? 1 Yas 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Hedical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

State Registrar

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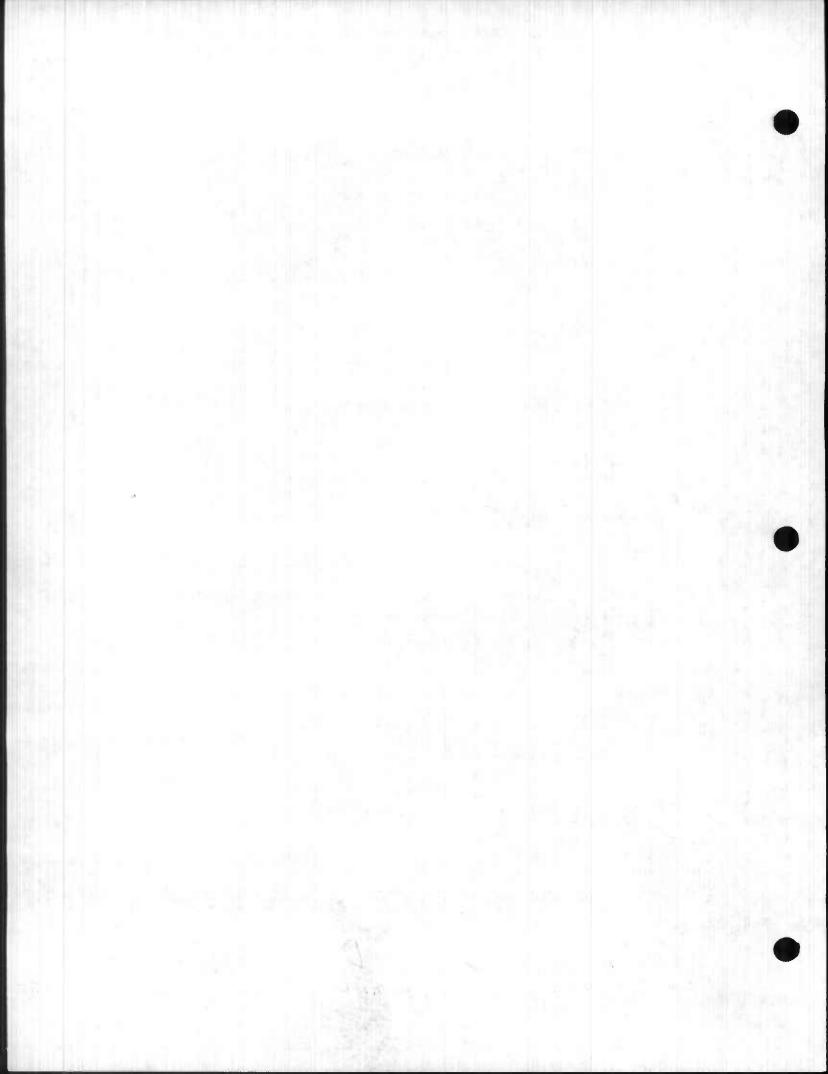
2 ER/Outpatient 3 DOA

28b. Time of

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

cause of seath (Item 23a) (Type) Prin

r's Signature

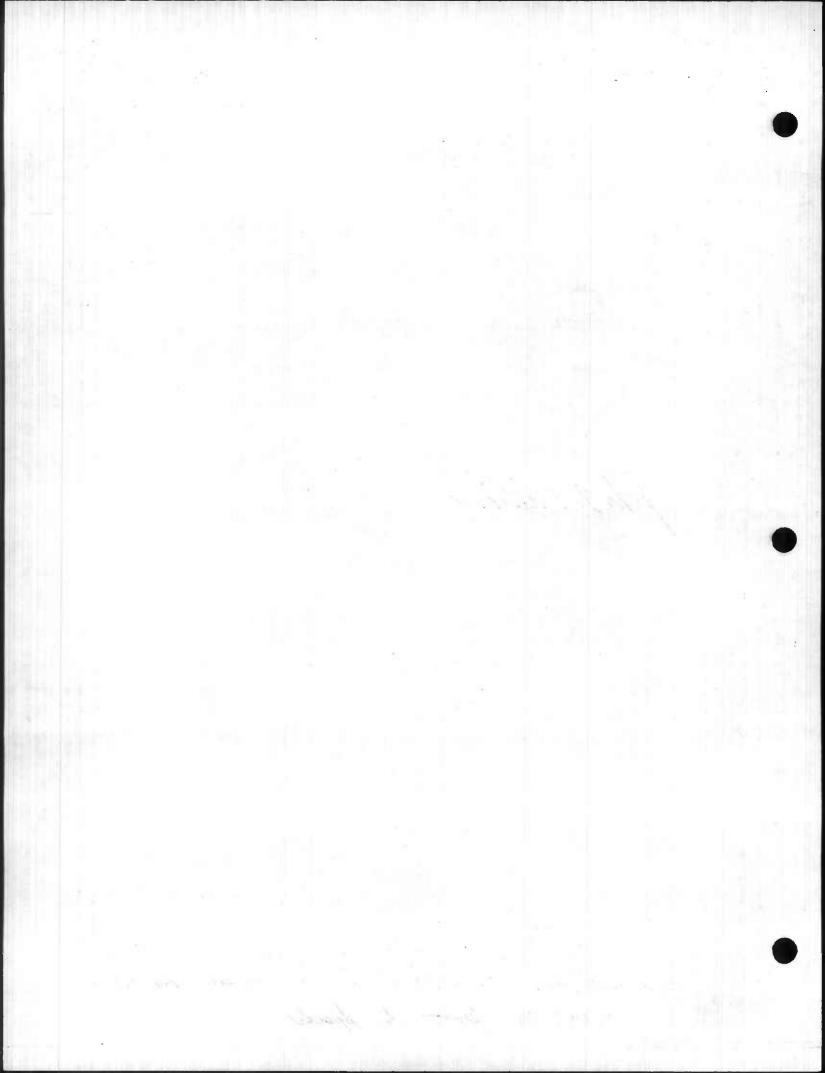


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Ce	rtifica	te of	Death		Re	g. No.	0	11;	598
Obveisio	1. Decedant'a Nama (First, Middle, La	st)					2.	Data of Death Month	_	Yaar	3. Time	of Death
ysician Medical	EMORY GLAD	DEN LAI	RD				1	Tarch.		000	05	26
miner	4a Facility Nama (If not institution, giv	ra street and number)				4b. City, To		ion of Death	4c. County	of Death		
	PENINSULA REGIO	ONAL MEDICAL	CENTER			SA	LISBU	RY	WI	COMIC	00	
ral tor	5. Social Security Number 6. S 227-46-4185 Usual Rasidence of Decedent	Y ODE	yrs. last birthday, Yrs.	Months	Days	If Under a	Min.	Data of Birth (Month, Day, 5/08/2	Year) 9	Coun	olace (State etry) RGIN	a or Foraign
	10a. Stata 10b. County	100	. City, Town or L	ocation						1	0d. Inside	City Limits
tor	VIRGINIA ACCOMACK		TANGIE	P							1)\(\) Y	as 2 No
Director	10e. Street and Number		17111011		p Code			10	g. Citizen of \	Whet Coun	itry?	
	16229 MAIN RI	DGE RD.				23440		100	11 0	5.A.		
Funeral	11. Marital Status	12. Was Decedent Evar Armed Forcas?	in U,S. 13.	Wes Dece			gin? (Specif	y Yas or No- an, atc.)	14. Rac	e - Americ		•
by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yas 2 ☐ No If Yas, Giva Yaar or Datas:				Specify:	, 1 0010 110	un, uto.)	Specify			
ete	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usu	al Occup	oation during most	of working	1	6b. Kind of B	usinass/Ind	Justry	54.33
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa.	DO NOT	ise retire	d)						
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88	17. Fether's Nema (First, Middla, Last)							irst, Middle, M		18)		
2	EMORY VEST  19a. tnformant's Name/Reletionship (	4,12,110	10h 14-9	ina Adda.	o (Const			Y SHOR		Ctata Ti-	Code	
	PEGGY PARKS LAI			Seat Seat 1				TANGI			440	
	20a. Mathod of Disposition		b. Place of Disp	osition (Na	ma of				CK, VA			
	1 Burial 2 Cramation 3		cematary, cre		711		1 2					
	4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		AIRVIEW			IE I E K Y		/26/00	ONANC	ULK,	VIRG	INIA
8	111	11/11					•	FUNERA	I HOME			
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or or use as the bunal-transmiller is the bunal-transmiller is the bunal-transmiller is the contract of the contract is the contract of the co	Sequentially list conditions, if any, teeding to immediate causa. Entar Undardying Cause (Disaasa or Injury that inkleted evants resulting in death) Last	с	to (or as a conse	quence of)	:	Dise						
cian	Dod II. Other elevities at any distance	on the time to double but any	anno bino la shar	and and the a		un in Bond I		ook Did to			Ab	a of death 0
Physician/	Part II. Other eignificant conditions of	ontributing to death but no	rasuring in tha t	indanying	causa gn	ven in Part I.			becco use co se 2 No	3 Prot		Unknown
Completed by								24a. Was ar perform		ava	are autops ailable prid mpletion o	or to
dm	VO., 10. 1										death?	71
	26 Was assa retarned to medical							1 Q/Ya		11	Yes 2	No.
To Be	25. Was casa retarred to medical axaminer?  1 Yas 2 No	Hospital:	2 ER/Outpatie	at all a	OA Ott	noc		5 Reside		ar /Ca'4	64)	
	27. Menner of Death	28a. Dete of Injury (Month, Day Yea			28c. Inju	4LJ NU	-	f. Describe ho			77	
ation	1 ☐ Neture 5 ☐ Panding 2 ☐ Accident invastigation		(r) Injury	м		rk? ∣Yas 2.∏t						
Certification:	3 Sulcide 6 Could not be detarmined	28a. Place of Injury - building, atc. (Sp	At homa, farm, st	reet, factor	ry, office		281	Location (Str City or Town		per or Rura	/ Routa N	umber,
edicai (	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my niner: On the basis of axar and mannar stated.	knowledge, daat nination and/or in	h occurred ivastigation	at the tin	ma, data and opinion, deet	d place, and th occurred	due to the ca at the time, da	use(s) and me ita end place,	enner as si and dua to	lated.	e(s)
Me	29b. Signatura and title of certifier			29	c. Licens	se number		29	d. Data signe	d (Month,	Dey, Year	r)
	1. 2	2			101	400	711		3 )23	100		
	30. Name and address of person who					10		usbury,			/	
	stephen Hearne, m		11400 c	51. 5	76 6	605	SA	ussury,	mo	2180	4	
State	31. Data tiled (Month, Day, Year)	32. Registrar's S	ignatura	6	1							

DHMH 16 Rev 6/95

Emory Laird 55# 227-46-4185

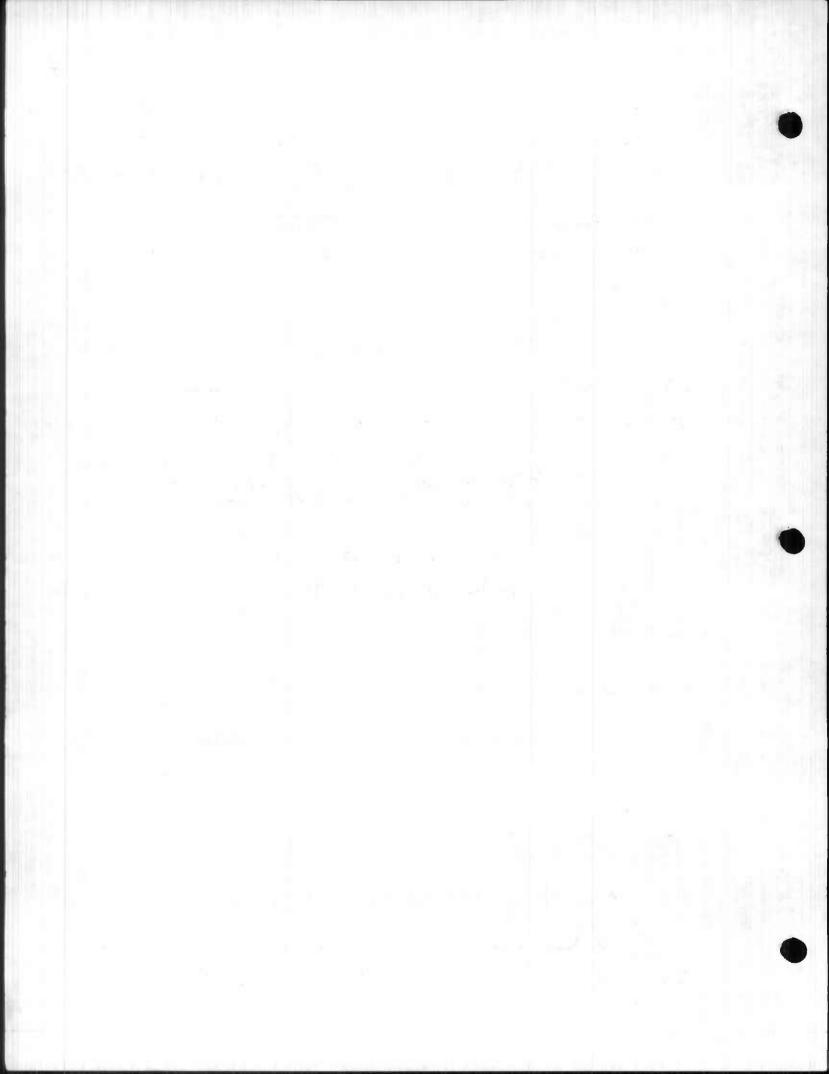


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month Day MABEL LOUISE MORRISON MARCH 26 2000 11:00 P.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20148 COOL HOLLOW ROAD WASHINGTON HAGERSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) SEPT. 24,1910 7. Aga (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1□M 2♥F Days Yrs 89 Director 212-38-9105 MARYLAND Usual Residenca of Decadent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner name be notified at 1 Yes 2X No Director MARYLAND WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20148 COOL HOLLOW ROAD 23a 21740 U.S.A. Funeral Hems 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yas 2X No If Yes, Give Yaar or Datas: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 ₩ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Ktnd of Businass/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 YEARS HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event ORGE. 18. Mother's Name (First, Middle, Maiden Sumame) JACOB S. McCAULEY EMMA GERTRUDE DETROW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KARL W. MORRISON/SON 20129 COOL HOLLOW ROAD, HAGERSTOWN, MARYLAND 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 03/30/00 BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensac 22. Name and Address of Facility 7606 OLD NATIONAL PIKE P. STEVEN DANFELT, JR. BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medicai Immediate Cause (Finat Cardiac disaasa or condition resulting in death) **Examiner** arres Due to (or es a consequence of): lein physician end s the buriel-transit certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of) USB as for use as The law requires that the death P.O. signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 3410 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 I Homicide edicai 156 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 10 0054451 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Myersville Maryland 3019 Ventice Donham Brian 32. Legistrar's Signature State Registrar

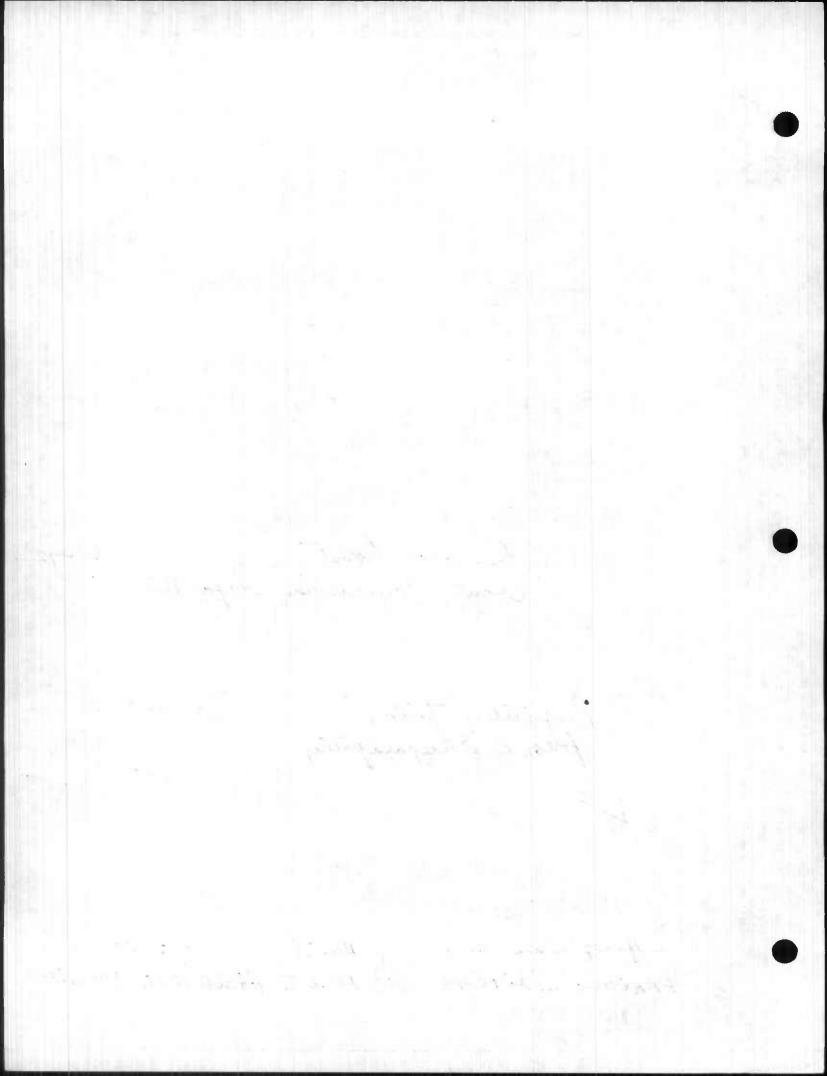


State of Maryland / Department of Health and Mental Hygiene

11600.

				Certificate of	of Death	F	leg. No.	00	1100
	1. Decedent's Nema (First, Mi	ddia, Last)				2. Data of Dea Month		Year	3. Time of Deat
Physician /Medical	Mary Carol:	ine Mowen				manal	Day 27 7	000	2116
Examiner	4a Facility Nama (If not institu	tion, giva street and number)			4b. City, Town, or I		4c. County		
31 L 11	Washington Co	ounty Hospita	1		Hagerst	own	Washi	nator	County
Funeral	5. Social Security Number		a (In yrs. last birthe	day) If Undar 1 Ye	ar If Undar 24 Hrs.	8. Date of Birth (Month, Day	1		placa (Stata or Fore
. Director	220-30-9819	1  M 2 💢 F	71 Yr	s. Months Da	ys Hours Min.	Apr. 30			land
70	Usual Rasidence of Decedant								
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E B B B	19a. Informant's Name/Ralatio	onship (Type, Print)	19b. N	Mailing Addrass (Str	eet and Number or Ru	ral Routa Numbe	r, City or Town	Stata, Zip	Code)
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requires that the death ce een signed by the ettendi hould be deteched for us,	1	Alle	2	0 0-	. 17	24a. Was a	an autopsy	24b. W	ara autopsy tindii vailabla prior to
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et o	1 Natural 5 Pan	ding 28a. Data of Inju	y Year) 28b. Tin		njury at Work?	28d. Describe h	ow injury occur	1180	
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Director: d in by the		rmined 200. Placa of In	jury - At homa, farm c. (Specify)	, straet, factory, off	ice	28f. Location (S City or Tow		ber or Hun	al Routa Number
within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi									
in 24 hour he Funeri pletely fill edical	29a. Certifier 1 Certifi	ying Physician: To the best al Examiner: On the besis o							
within 24 hours and to the Funeral completely filled	one)	and mannar st		or investigation, in in	ny opinion, deem occu	rred et trie time, t	ete enu piace,	and oue t	O tria ceuse(s)
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	Enau)cisc	1 L ANDR	A02-	250 M	146.07	HAGER	TOWK	1 M	102174
	31. Date filed (Month, Day, Ye	ari 20 Bodon	ar's Signature		/				
State Registrar	MAR 2		ars Signature	9. In	1				

Registrar



Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 28. 2000 Ruth Heinzman Moulden 7:40 P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Avalon Manor Health Care Center Hagerstown If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV. 23, 1901 9. Birthplace (State or Foreign Funeral Days 1□ M 2□ F Months 196-05-6609 Pennsulvania 98 Director Usual Residence of Decedent 10a. Stafe 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Washington Smithsburg Md. 1 Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 2 Box 243 21783 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel hygiene. Important if from 27 is marked other than "natural", or have fillural. 1 Never Merried 2 ☐ Merried White 1 Yes 2 No Specify: by 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 William J. Heinzman Bertha A. Heckman 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (Self) Rt. 2 Box 243 Smithsburg, Md. 21783 Ruth H. Moulden 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20s. Method of Disposition 20c. Location - City or Town, Stete MayPate 31 Buriel 2 Cremation 3 Removal from State
Constion 5 Other (Specify) hewsville Cemetery 2000 Chewsville. Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 29 Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 3 weeks neymonia Examiner Due to (or es e consequence of) naum ynamm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pug Due to (or es a consequence of): physician Due to (or esta consequence of): Physician/Medical the th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed peen s 2 K No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funaral director; 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No B 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

State Registrar

(Check only one)

29b. Signature and title of certifier

Zafar Malik 31. Date filed (Month, Day, Year) 32. Registrer's Signeture MAR 3 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20311 Lappans Road, Boonsboro, MD 21713

Baltimore, Maryland 21215-0020

Box 68760,

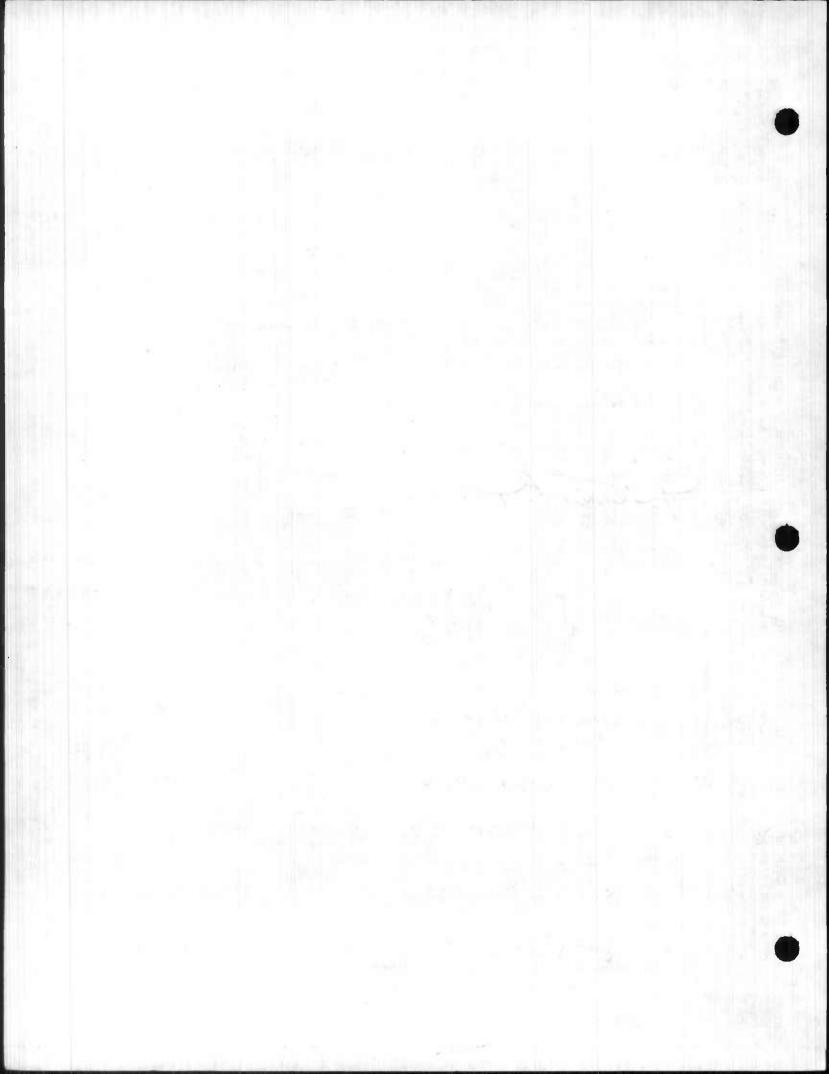
Division of Vital Records, P.O.

29c. License number

144996

29d. Date signed (Month, Day, Year)

March 29, 2000



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) WILLIAM E. MILTO 4. Facility Name (If not Institution, give street and number) 4. County of Death

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiere.
Important if I lean 27 is marked other than "natural", or them 22a or 21a-1 show any injury or other traumatic event, the Medical Examiner must be notified at other process.

Physici /Medic Examir

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit.

		WII	LLIAM E	MIL	TO			Month Mench	Day Det	Year 1600	
4a Facility Nama (If not it	institution, giv	ve street and n	rumber)			4b. City, To		ation of Death	4c. County		
PENINSULA	REGIO	ONAL ME	DICAL CE	ENTER		SAL	ISBUR	Y	W	ICOMICO	
5. Social Security Number 184-14-4704		Sex M 2□ F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Yes Months Day		Min	8. Dala of Birth (Month, Day, June 8,	Year) 1923	9. Birthplace (Stata of Country) Pennsylvar	
Usual Rasidence of Dece	edent County		1400 Cie	y, Town or Lo						Landania	
	Somer	anh.	100. CR		larion St	ration				10d. Insida Ci 1 ☐ Yes	
Maryland  10e. Street and Number	SOMET	set		**	10f. Zip Code			140	- Ohif1	What Country?	
27964 Tur	pin Ro	ad			Tot. Zip Code	21838		10	US		
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1 Nevar Married 2	-	Armed F	Forces?  2 No Wor  Notes War I	1d	If Yes, specify Cu 1☐ Yes 2ÊN	ıban, Mexican	, Puarto R	ican, atc.)	Specify Specify	ck, White, etc. y: White	
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William William						18. Motha		h Baker	aiden Surnan	na)	
19a. Informant's Name/R	Ralationship (	Type, Print)		19b. Mailir	ng Address (Stre	et and Numbe	er or Rural	Routa Number.	City or Town.	State, Zip Code)	
Kathy Hun			er)		78th St					318	
20a. Mathod of Dispositio	on mation 3	Removal from	20b. P	Place of Dispo	esition (Nama of matory or other p	lace)	03	Data 2	Oc. Location	City or Town, Stata Leld, MD	
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Mays	Pott No	OBLOO	blaw		Brads	haw &	Sons	Funeral			
Mary Bet 23a. Part1. Enter tha dis-	th Noe			h. Do not ent	306 W	. Main	St.	- Crisf	ield,	MD 21817	
shock, or heart failu	ire. List only	one cause on	aach line.	II. DO NOT BIN		yang, such es	Cardiac of	-	st,	Intarval Bet	reen
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disaasa or condition rasulting in death)		a.     T	Spra	own	UVIE	un	MU	a		241	W.
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Cause (Disease or Injury that initiated events	- 5	C	Due to (o	r as e conseq	juence of):						
rasulting in death) Last											
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	M							24a. Was an periorm		24b. Wara autopsy I available prior t completion of c of death?	)
								1 ☐ Yes	2 No	1   Yes 2	No
25. Was case rafarred to	medical	N 4 - 5 -				26. Placa	of Death	(Check only ona	)		
axaminar?		Hospital:	Unpatient 2	ER/Outpatien	nt 3 DOA	Whor:		a 5 Rasidar		nar (Specify)	
27. Mannar of Death  1 [[]Netural 5 [ 2 [] Accident	Pending invastigation		a of Injury onth, Day Year)	28b. Time of Injury	W	ury at ork? □ Yas 2 □		8d. Describe how	v injury occur	red	
3 ☐ Suicide 6 ☐ 4 ☐ Homlcide	Could not b determined	200. Plac	ce of Injury - At ho ding, etc. (Specif)	oma, farm, str y)	reet, factory, offic	8	28	Bf. Location (Stra City or Town,		ber or Rural Routa Num	)0r,
10mode				-dadas dash							
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29a. Cartifier 1970 (Check only one)	f certified	and mai	basis of examinat	MI 23e) (Type	29c. Lice	nse number	th occurred	d at the time, da	d. Date signe	and due to the cause(s ad (Month, Day, Year)	20

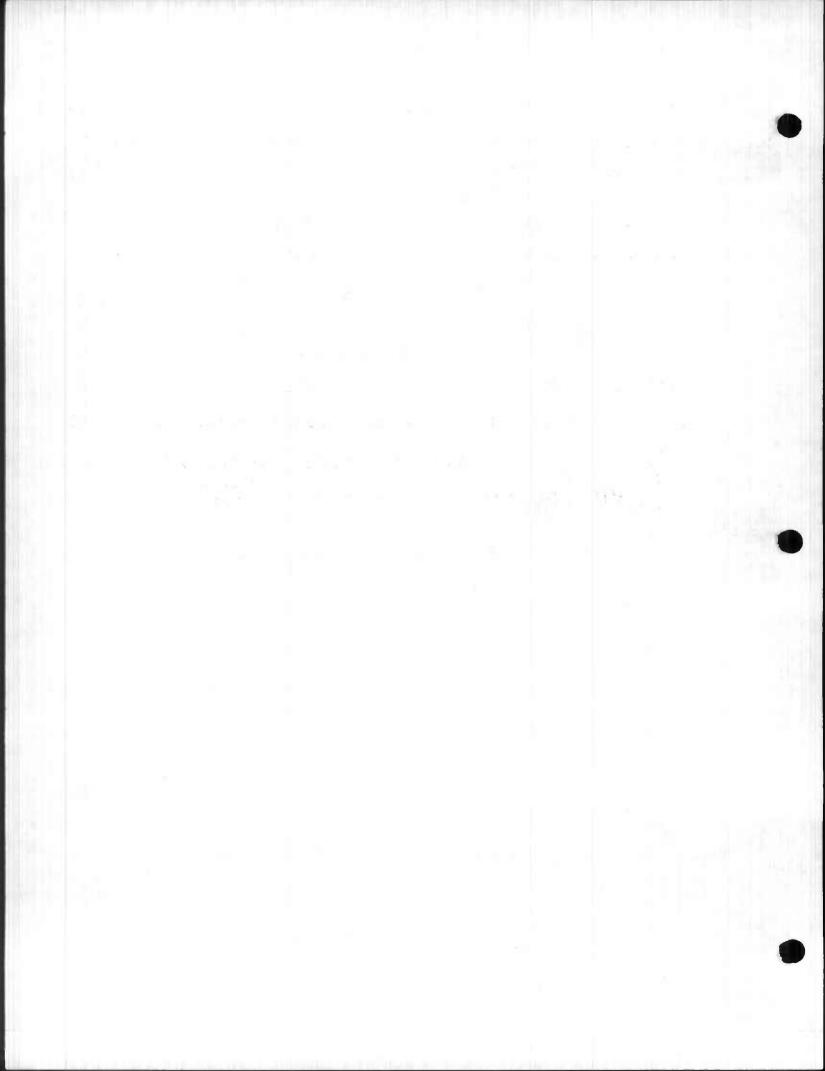
State Registrar

MAR 2 2 2000

Beneva G. Sparks

State of Maryland / Department of Health and Mental Hygiene 00 | 1603

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/Medic		IVA WENT  4e. Facility Nama (If not Institution, given		PIII	IAIN	4	b City Town	MARCH or Location of Dea		
Examin	er									
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MON		10a. Stata 10b. County		10c. City, Tov	vn or Location					10d. Inside City
Page 1	to	MARYLAND WASHIN	IGTON				BOONS	BORO		1 Tas 2
Y 28	ire	10e. Street and Number			10f. Z	ip Coda			10g. Citizen of W	hat Country?
23a c	alD	21176 SAN MAR ROA	AD				21713		U. S	S.A.
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item 2		20e. Mathod of Disposition	70	20b. Place o camata	of Disposition (Nary, cramatory or	ama of r othar plac	a)	Data	20c. Location - 0	City or Town, Stata
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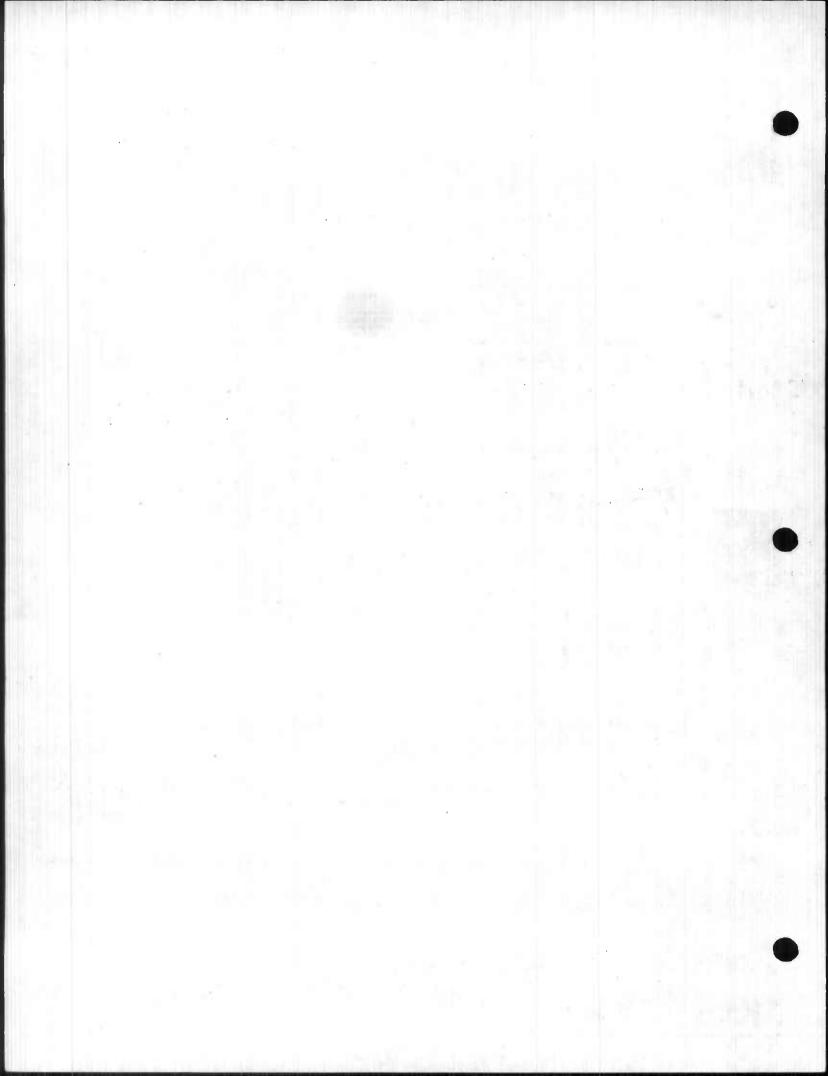
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 11601.

1.	Decedent's Name (First, Middle,	Last)						2. Dete of D	eeth			ime of Death
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	039-26-2134 sual Residence of Decedent	15 M 2 F	56	Yrs.			urs Min.	8. Date of Bi (Month, D			Birthplace (S Country)	sland
	De. State 10b. County		10c. Cit	y, Town or Loca	ation						10d. Ins	side City Lim
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

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ohrer					Marc	ch 27	2000	0400
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County Hospi		1 4/14		Hagers	town	Wa	shing	
6. Sex 7. Age 1	ga (In yrs. last birt	hday) If Under Months	Days	If Under 24 Hrs Hours Min.	8. Data of B	lay. Year44	9. Birth Peny	placa (Stata or Foi intry) USYLVANIC
	10c. City, Town	or Location						10d. Inside City Lie
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igzon		10f. Zio				10g. Citizen	What Cou	
Grove Rd.		101. 2.4	217	12			S.A.	nuy:
12. Was Decedent I	Ever in U,S.	13. Was Deced		spanic Origin? (S n, Mexican, Puer	Specify Yas or N		ace - Amari	can Indian,
Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Datas:	No	If Yes, spec			to Rican, atc.)		Black, Whila, city: Vhu	
Education	16a.	Decedent's Usua	l Occupi	tion	4.5-	16b. Kind of	Businass/Ir	ndustry
grada completed)  College (1-4or 5	5+)	Decedent's Usua (Give kind of wor lifa. DO NOT us	e retired	uning most or wo	rking	.,		
		Homem	arer				ome	
ast)				18. Mother's Na				
endall Sr.					ry E. Sa		7	
rer (Son)		Mailing Address						
tel (30n)	and the same of th	13609 Po			Data	20c. Location		
3 □Remover from State scify)		Disposition (Nan y, cramatory or o Creek C			Mar. 30,	Beave		
censu	5,	22. Name an	d Address Fune	s of Facility ral Home	12525 Smith	Bradbu	ry Ave	, , , ,
omplications thet caused nly ona cause on each lin	the death. Do n							Approximate Intervel Batwee
c	Due to (or as a co			749				MKnow
d							1	
s contributing to death bu	ut not resulting in	the underlying ca	ause give	n in Pert I.	23b. Did	tobacco use	contribute t	to the cause of de
hobia					10	Yes 2 N	3 Pro	obably 4 Uni
					24a. Wa	s an autopsy formed?	C	Vare autopsy find vailable prior to ompletion of caus I deeth?
						Yas 2 No		□Yas 21 No
				OC Place of Da				145 20040
Hospital:	nt 2 MER/Out	patient 3 DO	Othe	26. Place of De	toma 5 ☐ Res		Wher /Spec	ih i
28a. Date of Injur (Month, Day		ima of 2	Bc. Injury Work			how injury oc		197)
tion (Month, Day	y rear) in	ijury M		res 2 No				
28a. Place of Injubuilding, atc	ury - At home, fan c. (Specify)	m, street, factory	, office		28f. Location City or To	(Street and Nu own, Stata)	mber or Rur	ral Routa Number
Physician: To the best of caminer: On the basis of and manner ste	axamination and	death occurred a Vor investigation,	at the tim in my op	e, date and place inion, deeth occu	e, and due to the urred at the time	e cause(s) end , date end plac	menner es s e, end due t	stated. to the cause(s)
		290	. License	number		29d. Date sig	ned (Month,	Day, Year)
en			D.	38471	/	Marci	(28	2000
ho completed cause of de	eath (Item 23a) (I	Type, Print)			A			
22911	Toff	Prsin	RI	2 61	mithe L	line	ml	
		6	,		111111	wy,	1-6-	
		2291/ Joff 2000 32. Registrar's Signatura			oz. Hogistat s digitatula	Oc. Hogistal's digitatula	oc. Hogistal a digitatula	



State of Maryland / Department of Health and Mental Hygiene

10		1	6	n	F
	- 1		V	V	-

**Physician** /Medical Examiner

Director

3. Time of Death 8:50pm

**Funeral** 

Director

with the Meryland 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at death

permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural, or item any Injury or other traumatic event, the Hodge Exercises

altimore, Maryland 21215-0020

**Physician** /Medical Examiner

Examiner

Physician/Medical

þ

29a. Certifier

(Check only one)

physician and the buriel-transit 980 this

Hospital or Attanding Physician: efter deeth. 24 hours e Within 2 To the

Division of Vital Records, P.O. Box 68760

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth MaYCh 27° 2000 eer Cyrus David Robinson Jr. 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth 13640 Cresspond Road Clear Spring Washington 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. Dec . 24, 1954 5. Social Security Number 1**X**0 M 2□ F 213-68-6608 MD Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Clear Spring 1 ☐ Yes 2 No MD Washington 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21722 U.S.A. 13640 Cresspond Road 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Bieck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry entery/Secondery (0-12) construction College (1-4or 5+) mason/laborer 10th grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Josephine Louise Carrier Cyrus David Robinson Sr. 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
12433 Gateway Ave. Hagerstown, MD 21740 19e. Informent's Name/Reletionship (Type, Print) J.Louise Wright Mother Mar. 28, 2000 20b. Piace of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Donald Edwin Thompson Funeral Home, Inc Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately a such as cerdiac or respiratory errest,

Approximately a such as cerdiac or respiratory errest, Approximate Interval Between Onset end Deeth Immediete Cause (Finel diseese or condition resulting in death) Due to (or es e consequence of) tepatorenal Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown chronic renal failur 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to nepati failure completion of ceuse of deeth? Esophqual varices 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical exeminer?

1 Yes 2 No 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28c. fnjury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

1 Certifying Phyefcfan: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner as steted.

of person who completed cause of deeth (item 23a) (Type, Print)

32. Registrer's Signatur

Ruta linghug, mD

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner steted.

29c. License number

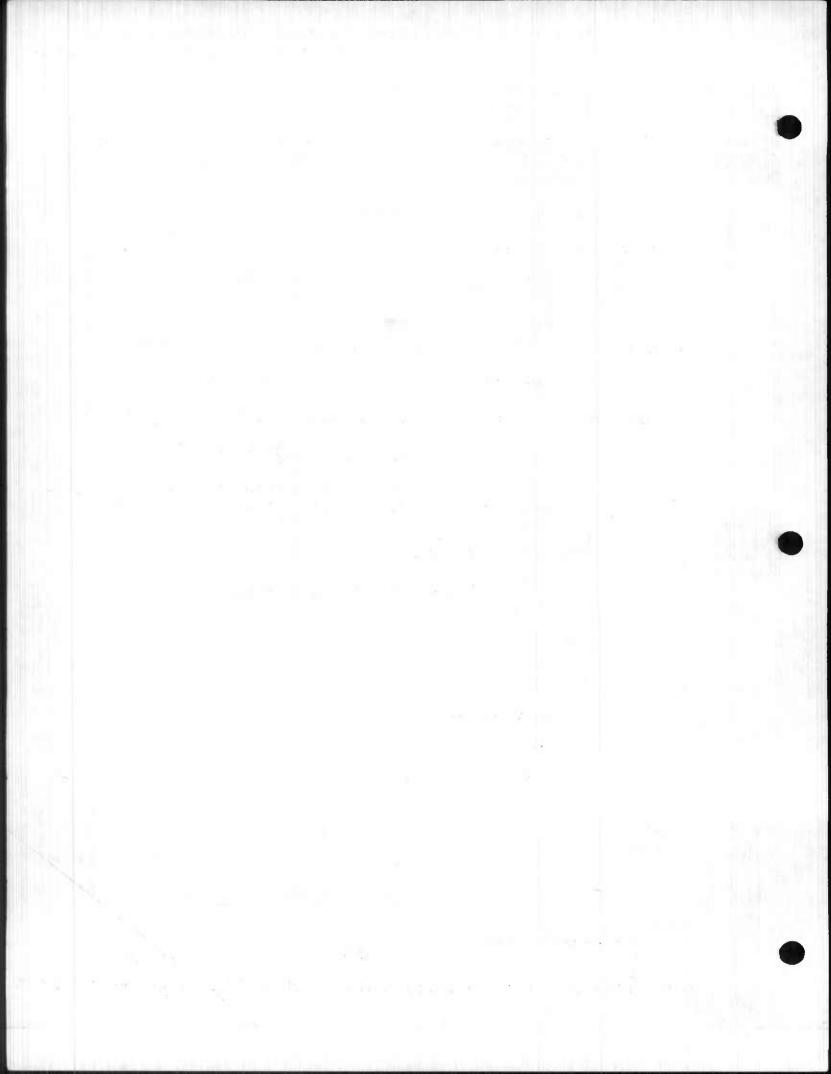
D00 50882

11110 medical Campus Rd. Ste#107 Hagerstown, Md 21742

29d. Date signed (Month, Day, Yeer)

State Registrar

Medical



State of Maryland / Department of Health and Mental Hygiene 11607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 26, 2000 0215 March Milton Elmer Roberts Jr. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert 2400 Fawn Court. If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Oct 28, Birthplace (State or Foreign Country)
 VA **Funeral** Months Days Hours 1∰M 2□F 62 224 48 3534 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits ahow the Maryla MD Prince Frederick Calvert 1 Tyas XX No Director 'natural', or harms 23s or 28s-f 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 20678 USA 2400 Fawn Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status 14. Rece - American Indien, Black, White, etc. hours after 1 Yes 2 No
If Yes, Give 1956-62
Year or Detes: 1 Never Merried 2 Merried white Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) U.S. Gov't. pest controller 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental Is marked Milton Elmer Roberts, Sr. Fannie Brandenburg Purdum 19a. Intermant's Neme/Reletionship (Type, Print) 19b. Meiting Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra Sarah D. Roberts (wife) same as 10 above 20b. Place of Disposition (Name of cemetary, cremetory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, Slete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 3-27-00 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility
Rausch Funeral Home, Owings, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** LUN Mayth ancer /Medical Immediete Causa (Finel diseese or condition resulting in deeth) Examiner Dua to (or es e consequance of) Examiner attending physician and for use as the buriaf-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Diseesa or injury that initiated evants resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 10 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 25. Was case reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? After 5 Panding 1 Neturel death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide within 24 hours a To the Funeral D completely filled McCortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. edicai 29a. Certifier To the 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 27-2000 15 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD 20678 1 JA Bruce Silver, M.D. 31. Date tiled (Month, Dey, Year) 32. Registrer's Signeture State MAR 2 7 2000 \ Registrar

DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 25, 2000<sup>Year</sup> Collins Rymer

4b. City, Town, or Location of Death

Prince Frederick

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Days

11608

3. Time of Death

0225

Birthplace (State or Foreign Country)
 NO

4c. County of Death

Calvert

29d. Date signed (Month, Day, Year)

8. Date of Birth (Month, Day Year) Oct 25, 1897

**Physician** /Medical Examiner

Amy

5. Social Security Number

578 40 8625

4a Facility Name (If not institution, give street and number)

Calvert County Nursing Center

1□ M 2 F

7. Age (In yrs. last birthday)

102

**Funeral** Director

or items 23s or 28s-f show

permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Heelth and Mental Hygiens. Department of Health a Important: if Item 27 leany injury or other tra

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, is centificate has been signed by director, page 2 should be detec-

To the Mospital or Attending Physician: The law requires that the death certificate be assected within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completaly filled in by the funeral 3

MD	10b. County Ca	lvert	Prin	rown or Location ce Frede	rick					ide City Limil Yes 2 N
10e. Street and Nu	mber Hospital	Road		10f.	Zip Code 20678	}		10g. Citizen of V	What Country? USA	7 1
11. Marital Status 1 ☐ Never Man 3 ☑ Widowed	ied 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:		If Yes, s	specify Cuban, i	anic Origin? (. Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		e - American Inde ck, White, etc.	
(Sne	15. Decedent's Ed	ducation ade completed)	1	16a. Decedent's U	Isual Occupation	n na most of w	ndkina	16b. Kind of Bu	usiness/Industry	
Elementary/Second		College (1-4or 5	5+)	clerk	Tuse retired)			U.S. N	avy	
17. Father's Name Nicholas	(First, Middle, Last, S Arring		lins			Mother's Na annie		n, Maiden Suman Rives	10)	
	ame/Relationship (	Type, Print) Sr. (son)		19b. Mailing Address 4835 Ba				per, City or Town, e Beach,		
		Removal Irom State	cem	ce of Disposition (for betery, crematory of anuel UM	or other place)	Cem.	Date 3-28-00		City or Town, Ste	
21. Signature of Fo	geral Service Licer	1500	1		and Address of ch Fune		me, Owir	ngs, MD	20736	
shock, or hea	rt tailure. List only	plications that caused one cause on each lin	ne.		node of dying, s	such as cardie	ac or respiratory a	arrest,	Interve	ximate al Between and Death
shock, or hes tmmediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to in cause. Enter Unde	(Final in additions, moditions, moditions, moditions)	a. PN51	UMON		of):	euch as cardie	ac or respiratory a	arrest,	Interve	al Between
shock, or heat tmmediate Cause disease or condition resulting in death)  Sequentially list co if any, leading to in	(Final inditions, inditions, injury injury	a. PNE	Due to (or as	V) D	of):	uch as cardie	ac or respiratory a	arrest,	Interve	al Between
shock, or hes tmmediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to in cause. Enter Undo Cause (Disease or that initiated event resulting in death)	rt tailure. List only (Final in	a. PNE	Due to (or as	s a consequence of a consequence of a consequence of	of): of):		23b. Did		Intervious of the call of the	al Between and Death  Duy  ause of deat
shock, or hes tmmediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to in cause. Enter Undo Cause (Disease or that initiated event resulting in death)	rt tailure. List only (Final in	a. PNE	Due to (or as	s a consequence of a consequence of a consequence of	of): of):		23b. Did 1 □	l tobacco use co	ntributa to the ca	Duse of death
shock, or her Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Undo Cause (Disease or that initiated event resulting in death)  Part II. Other significant	inditions, meditions, meditions, meditions, meditions, meditions, meditions and meditions conditions condition	a. PNE	Due to (or as	s a consequence of a consequence of a consequence of	of): of):		23b. Did 1 □ 24a. Was	l tobacco use cod Yaa 2□ No s an autopsy	ntributa to the ca  3 Probably  24b. Were autovailable completio	and Death  Duy  Buse of deat  Unknot oppy findings prior to on of cause
shock, or heat timmediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Undo Cause (Disease or that initiated event resulting in death)  Part II. Other significant in the condition of the cause o	red to medicat	b  d  Hospital:	Due to (or as	s a consequence of a consequence of a consequence of a consequence of the consequence of	of): of): of): of): Of): Of): Other	n Part t.	23b. Did 1 □ 24a. Was peri	l tobacco use con   Yea 2 □ No   san autopsy   ormed?   Yes 2 ⊠ No   one)	ntributa to the ca 3 Probably  24b. Were auto available completio of death? 1 Yes	and Death  Duy  Buse of death  Copy findings  prior to  n of cause
shock, or hea  Immediate Cause disease or condition resulting in death)  Sequentially list co if any, leading to in cause. Enter Und cause (Disease or that initiated event resulting in death)  Part II. Other signif	red to medicat	b	Due to (or as  Due to (or as  Due to (or as  Due to (or as	s a consequence of a consequence of a consequence of	ort):	n Part t.	23b. Did 1 □ 24a. Was peri 1 □ eath (Check only) Home 5 □ Res	l tobacco use co l Yea 2□ No s an autopsy ormed? Yes 2≸No	ntributa to the ca 3 Probably  24b. Were autovariable completic of death? 1 Yes	and Death  Duy  Buse of deat  Unknoopsy findingsprior to on of cause

**DHMH 16 Rev 6/95** 

State

Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

30. Name and address of person who comp

Charles M. Judge,

MAR 27

Prince Frederick, MD

d cause of death (Item 23a) (Type, Print)

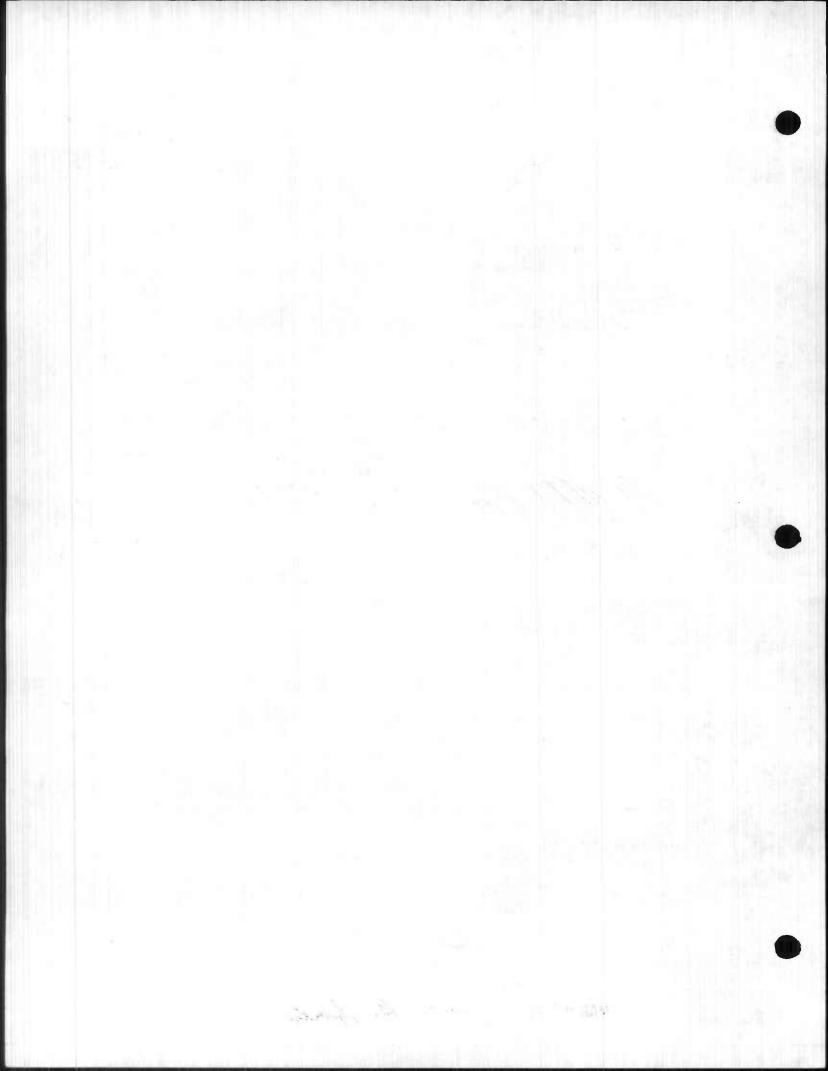
32. Registrar's Signature

M.D.,

2000

29c. License number

20678



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEMS: #17,18 PER MEO G783 5-State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #5, 17,18 PER F.H. G782 4-28- Wertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physician Month SYLVESTER TERRY RICHARDS 2000 March 28, 1219 /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Easton Memorial Hospital If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Dete of Birth (Month, Day, Year)
Dec. 13, 1960 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) M 1 S S 1 S S 1 p p 1 **Funeral** Months J M 2□ F 39 Yrs. Director **Usual Residence of Decedent** with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Denton MD Caroline 1⊠Yes 2□No Director a 23a or 28a-f nust be notifie 10a. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 21629 305 Market Street Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Stalus 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian Bleck, White, etc. hours after 1 Never Married 2 ⋈ Married 1 Yes 2XXIO If Yes, Give Year or Detes: B Black 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chicken Catcher Poultry 10 permit. Pages 1 and 2 should be life.
Department of Health and Mental Hyg.
Important if Item 27 is marked
any Injury or other Maryland 17. Father's Name (First, Middle, Last) LOUIS JUNIOR RICHARDS 18. Mother's Neme (First, Middle, Meiden Sumeme) 88 Martha Derrickson ALICE MAE CUSTIS James H. Robinson-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7846 Willing Court, Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Carol Richards/ Spouse 20b. Place of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete tery, cremetory or other place) 1 Burial 2 Cremetion 3 Removel from State Federal Hill Cemetery 4/1 Federalsburg, MD 4 Donation 5 Dother (Specify) 22. Name end Address of Facility
Framptom-Hawkins-Eskow
Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Funeral Home, PA Eskow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Septicemia 4 days Examiner Due to (or es a consequence of): The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): unding physician use es the burle Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown à Completed 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? certificate 1 ☐ Yes 2 ☐ No Attending Physician: director. å 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? After 1 Natural 5 Pending investigation death. 1 Yes 2 No apital or Attendi ours after death. werel Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edical ( Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

P.O. Records, Division of Vital To the Hospital within 24 hours a To the Funeral Completely filled

Box 68760.

Richards

Sylvester

James Elmore, 31. Date filed (Month, Day, Year) State Registrar MAR 3 0 2000

29b. Signature and title of postille

M.D. 219 S. 32. Registrar's Signature

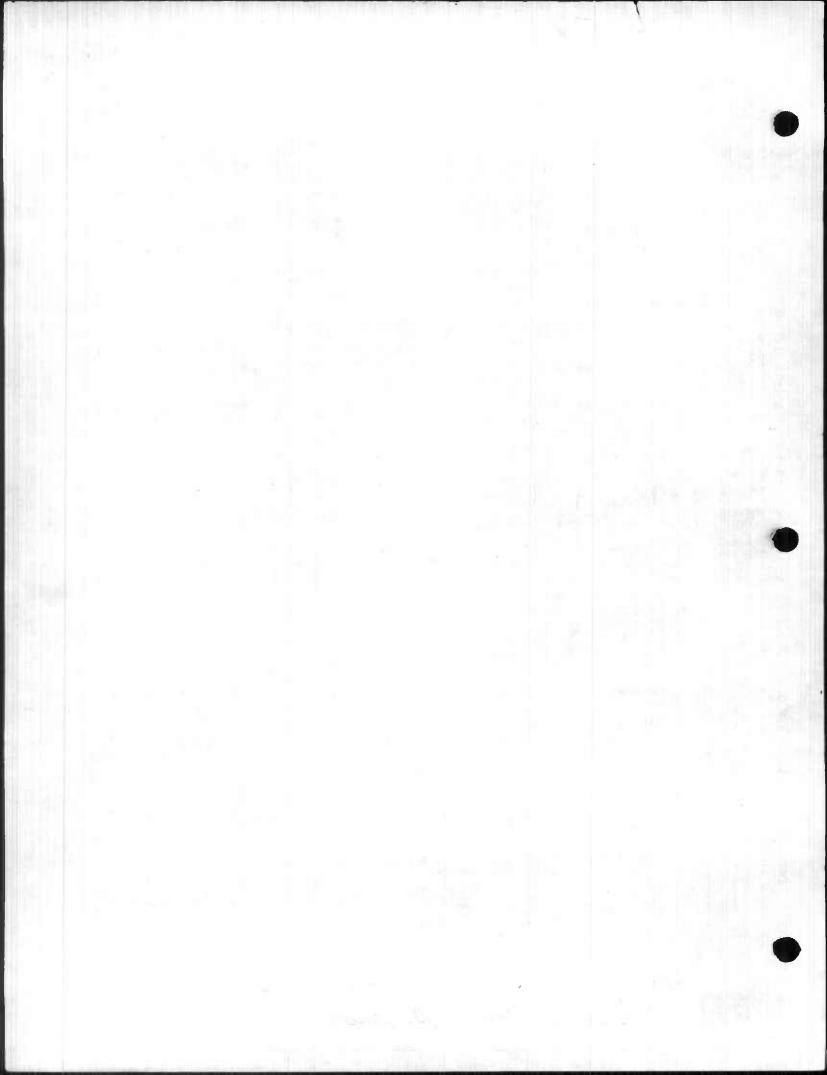
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington St., Easton, MD 21601

29c. License number

50325

29d. Date signed (Month, Dey, Year) Mm & 28717 2000



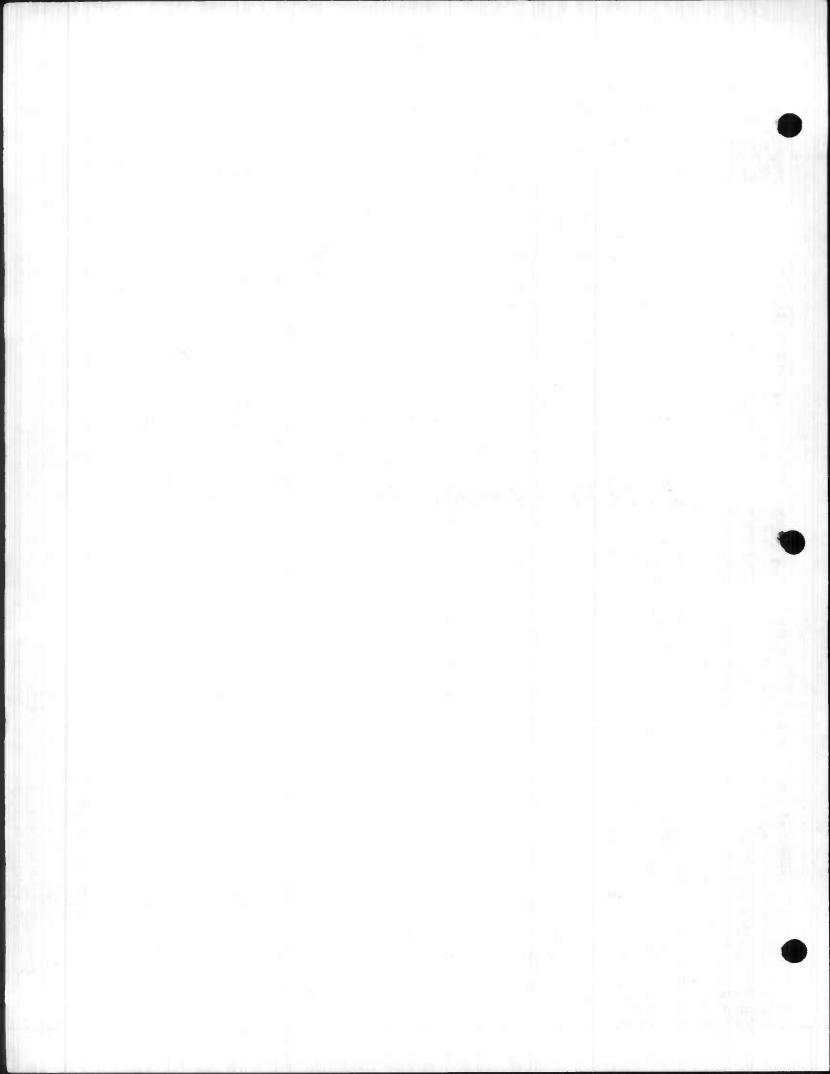
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Deta of Death **Physician** Month Morris James Stevenson, Sr. 25, 11:20 aim March 2000 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 E. North Avenue Hagerstown Washington 8. Data of Birth (Month, Dey, 5. Social Security Number If Undar 1 Yeer If Undar 24 Hrs. 7. Age (In yrs. lest birthday) Birthplaca (State or Foraign Country) **Funeral** Months Days 1₩ M 2□ F 216-30-2916 67 Yrs Director May 10, 1932 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location r 28a-f show a notified at 10d. Inside City Limits the Maryla Maryland Washington Hagerstown Director N Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 traumatic event, the Medical Examiner must be "natural", or Items 23a 29 E. North Avenue 21740 USA Funeral Was Decedent Ever In U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 X Yas 2 No If Yes, Give Year or Detes: 50-53 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important; if Nem 27 is marked other this any Injury or other the plumbers helper Fridinger-Ritchie 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Melden Sumema) Joseph Henry Stevenson Anna Mary Rae 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Glendora M. Stevenson Wife 29 E. North Avenue Hagerstown, Maryland 21740 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland Cedar Lawn Memorial Park3/29/00 Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximeta Intervel Betw Onsel and Deeth Physician Immediate Cause (Final disease or condition resulting in death) year Examiner Due to (or as a consequence of) Examiner and entially list conditions leading to immediate Enter Underlying (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician certificate be Physician/Medical that initiated events resulting in death) Last 8 Dua to (or as a consequence of) 8 aften for u The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 2□ No 3 Probably 4 Unknown à 8 24b. Wara autopsy findings available prior to Completed 24e. Was en autopsy performed? completion of cause of death? has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No oertificate Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To ↑ Yes 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Dey Year) 27. Manger of De 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident d in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) after A 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in artifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner as stated.

In medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 32. Registrar's Signature 363 Date filed (Month, Day, Year)

MAR 2 7 2000 Larmo State Registrar

**DHMH 16 Rev 6/95** 



FOR
STATE
REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1

STARTZ MAN BALTIMORE, MARYLAND 21215-0020

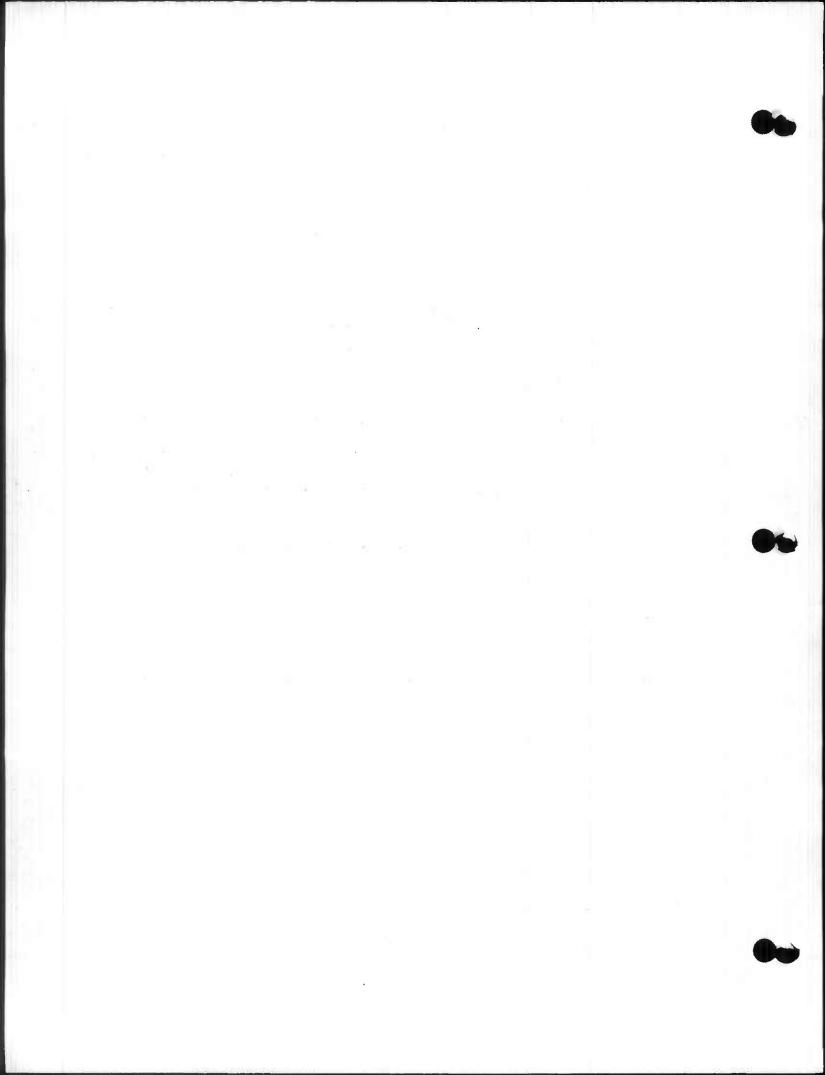
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

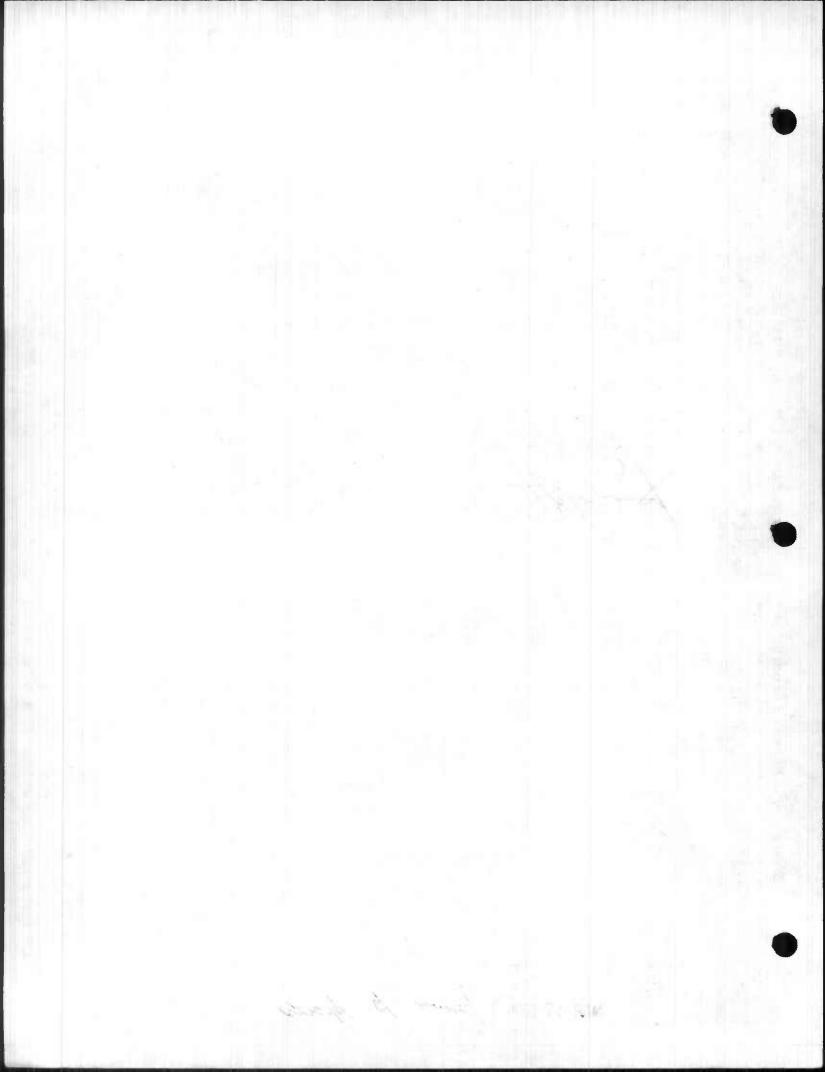
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	t. DECEDENT'S NAME (First	t, Middle, Last)	STARTZM	IAN, Jr.				ĺ	2. DATE OF DEATH DO March 26		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 219-12-2198		5, SEX	6. AGE (In yrs lest		F UNDER 1 YEAR		24 HRS. MIN.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTNE	PLACE (Stote or Foreign
OR	9a. FACILITY NAME (# not h 13413 High]	lane St			9	9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown Washingto						
ECT	RESIDENCE OF DEC	10b. COUNTY	,		10c. CITY.	TOWN OR LOC	ATION					10d, INSIDE CITY
DIRECTOR												LIMITS?  1 YES 2 NO
FUNERAL												
NE	13413 Highlane Street 21742 USA										USA	
BY FU	To the same of the									— American Indian, White, etc. White		
G	15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY											WILLEC
COMPLET	(Specify only highest grade completed)  Elementery/Secondary (0-12)  8  College (1-4 or 5+)  8  College (1-4 or 5+)  8  College (1-4 or 5+)  College (1-4 or 5-)  College (1-4 or											
BE CON												
70												
20e. METHOD OF DISPOSITION  1 XI Burlel 2 Cremetion 3 Removal from State  4 Donetion 5 Other (Specify)  21. SIGNATURE OF FUNEBAL SERVICE LICENSEE  20b. PLACE AND DATE of DISPOSITION (Name of cemetery, cremetory or other place)  Cedar Lawn Memorial Park  22. NAME AND ADDRESS OF FACILITY.											Maryland	
	MINNICH FUNERAL HOME											НОМЕ
	Co	as)	1/1/10	seried	/							Md. 21740
	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart failure.	List only one cal	isa on each ilne.						ratory arr	est,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju that Initiated eventa resulting in death) LAS	diata ING Iry		(OR AS A CONSEO	DENCE OF):	BRT	0/	jeaj	re			7
MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  ELLS fage vs. Ldz Dislage; Dialety, Hypher Renzion.  1 yes 2 no  24b. WERE AUTOPSY FRAMILABLE PRIOR TO OF DEATH?  1 yes 2 no									WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
IAN	25. WAS CASE REFERRED TO	O MEDICAL				26.	PLACE OF DI	EATN (Chec	ck only one)			
PHYSICIAN:	1 YES 2 NO		HOSPITAL:	ER/Outpetlant 3		THER:		/				
ВУ РНУ												
입	3 Sulcide 6	Could not be determined	25e. PLACE O building,	F INJURY — At hon atc. (Specify)	ne, farm, atre	et, factory, off	Ica		261. LOCATION (Street a City or Town, State)	nd Number	or Rural Ro	oute Number,
COMPLET									o the ceuse(e) end men			end manner as atated.
BE	296. SIGNATURE AND THILE		из				29c. LICE	NSE NUME	3 1 2	29d. DATE		Month, Day, Year) 28-00
٩	50. NAME AND ADDRESS OF	PERSON WHO	2930 D	SE OF DEATH (ITEM ACHILL	27) (Type, Pri	ini) 2GER.	500	LN,	21782			
	ELI ROZA  31. DATE FILED (MONTH, Day, MAR 2	9 200	32. REGISTRA	R'S SIGNATURE	9.	Spar	2	r				



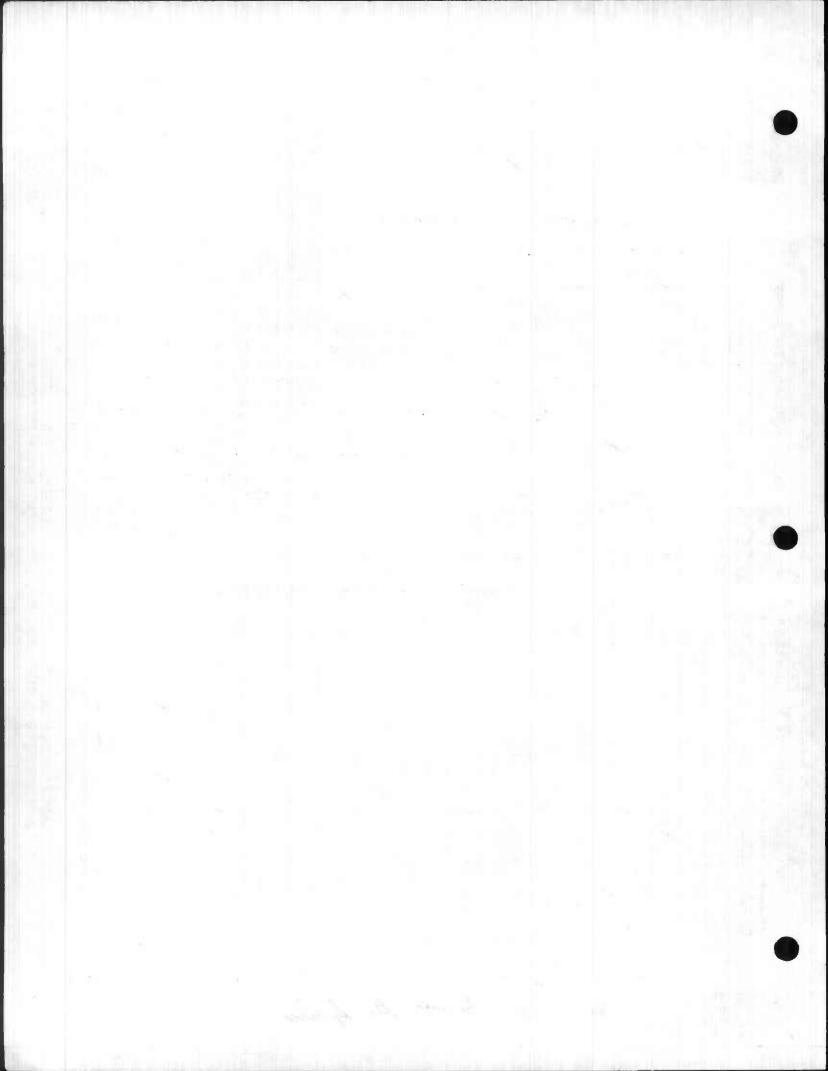
State of Maryland / Department of Health and Mental Hygiene 00 11612

					Cei	tificate of	Death			Reg. No.	•	1012:	
		1. Decedent's Name (First, Middl	e, Last)						2. Date of De	ath		3. Time of Death	
	Physician	Barba	ra Anr	ne St	ceidel				March	25.	2000	4:30 A.M.	
	/Medical Examiner	4a Facility Name (# not institution			CIUCI		4b. City, To	wn, or Lo	cation of Death		y of Death	4:30 A.M.	
	Examiner	Calvert Mem					Dring	- Em	ederick			_	
-	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year					alver		
	Funeral		1□ M 25 F		V	Months Days		Min.	8. Date of Bir (Month, Da	y, Year)	Coun	place (State or Foreign	
	Director	219-48-3081 Usuai Residence of Decedent		5	3				FEB. 21,1947 Maryland				
3	R-10	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										Od. Inside City Limits	
	4 P						1 ☐ Yes 2 TNo						
- 4	or 28a-f a be notified Director	Maryland Calve		40- 02	110000								
46	0 0 D					10f. Zip Code				10g. Citizen of		лгу г	
4	ra 123	5589 Stephen Re				20639				U. S			
1215-0020	r term 23s or 28s-1 show	11. Marital Status	Armed F	cedent Ever in U orces?		Was Decedent of I Yes, specify Cut	Hispanic On ban, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)		ca - Americ ick, White,		
2	200	1 □ Never Married 2 Marr	II YAS LE	2 No ive No		I Yes 2 No	Specify:			Specia	h-		
0	*natural', o	3 Widowed 4 Divorced	Yeer or I			X				Ороби	Whi	.te	
21215-0020	ygiene. her then "naturn t, the Medical Completed	15. Deceden (Specify only higher	t's Education	)	16a. Deced	lent's Usual Occu kind of work done	pation during mos	t of worki	na	16b. Kind of B	usiness/Inc	dustry	
7	then the the	Elementary/Secondary (0-12)		1-4or 5+)	life. L	OO NOT use retire	ed)						
CA 2	12	12			Bank	Teller				Bank			
pur l	II SE A	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maiden Sumer	ne)		
<u>a</u>	Mental arked o atic ev	Charles Gamage					Anna	Dod	d				
Maryiand		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Stree	t end Numbe	er or Rura	I Route Numb	er, City or Town	, State, Zip	Code)	
¥ ,	5625	Richard C. Stei	idel / Hus	sband	5589	Stephen	Reid	Road	Huntin	gtown,	MD 2	20639	
0	155	20a. Method of Disposition		20b. I	Place of Dispo	sition (Neme of		12.6	Date	20c. Location	- City or To	own, State	
mor	o m o	1 ☐ Burial 2 Cremetion	3 □Removal from	State		netory or other ple	909)		arch				
Baltimore	Department of Important: If I henry or page.	4 □ Donation → □ Other (S		Le	ee Crem					Clinton			
39	mpo my ir any ir	21. Eignature of Eucoval-Sorvice	Licensee									ert, P.A.	
-	10 = 0 a	Air	N N	101095	81	25 South	nern M	D BT.	vd. Owi	ngs, Ma	ry1an,	nd 20736	
		23a. ant 1. Enter the disease or shock, or heart failure List	complications that	caused the deal	th. Do not ente	er the mode of dy	ing, such as	cardiac c	r respiretory e	rrest,	1	Approximete Interval Between	
P	hysician	1	Ougrono oudoo on	ouori mio.								Onset and Death	
	/Medical	Immediate Cause (Final	Mani	adati	. 1.	00		-			1	1 was Mar	
E	xaminer	disease or condition resulting in death)	a. IVICT	March	- la	ng Cal	ncer				- 1	6 mon ths	
L.	<b>5</b>			Due to (	or as a conseq	uence or):					1		
3	in and fal-transit Examiner		b								i		
x 68760,	atending physician and for use as the burlal-transit cian/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (	or es a conseq	uence of):					1		
68760,	buri	Cause (Disease or injury that initiated events	с	C Due to (or as a consequence of):									
8	physicis to the bu	resulting in death) Last		Due to (d	or as a consequ	uence of):					1		
X	A Sing		d										
Box	or un												
. 6	00 -	Part II. Other significant condition	na contributing to d	leath but not res	ulting in the ur	nderlying cause g	iven in Part I		23b. Dld	tobacco usa co	ontribute to	the cause of death?	
O. 1	Phy etach								12	Yaa 2 No	3 Prol	bably 4 Unknown	
Records,	been si ahould leted									an autopsy	24b. We	ere autopsy findings ailable prior to	
0 5	D 6 -								pano	imed i	COI	mpletion of cause death?	
i Rec	page 2										100	/	
= 6	C pa								10	Yes 2 A No	1	Yes 20 No	
of Vitai	s certificate director, pag To Be Co	25. Was case referred to medical examiner?	Hospital:	1		10		of Death	(Check only o	one)			
Of the	T de	1 Yes 2 No	10		ER/Outpatien	1 3LI DUA		-		denca 6 □Ot		y) (y	
	After t funera	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Inju	ork?		28d. Describe	how injury occu	rred		
Division or Attending	death. tor: A / the fu	2 ☐ Accident investig	2 Accident investigation M 1 Yes 2 No										
7	Director: Jin by the ertifical	3 Suicide 6 Could r	ined 286. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						Street end Num vn, Stete)	ber or Rure	al Route Number,	
בֿ בֿ	a sher death.  I Director: After the in by the funera  Certification:			migration (opposit	"								
Hospital	y fill	29a. Certifier 1 Certifyin	g Physician: To the	best of my kno	wiedge, death	occurred at the t	ime, date an	d placa,	and due to the	cause(s) and m	anner as si	tated.	
ž.	within 24 hours after death.  To the Funerel Director: After completely filled in by the tuner of the funerel Certification.	(Check only 2 Medical i	Examiner: On the b	easis of examina mer stated.	ition and/or inv	restigation, in my	opinion, dea	th occurr	ed at the time,	date and place,	and due to	the cause(s)	
Toth	Vithic the comp	29b. Signature and title of certifier				29c. Licen	se number			29d. Date şigne	ed (Month,	Day, Year)	
	> - 0	1/1	AR	ad.	u.	NU	523	5		3/1	-/1	0	
		College	2100	yun !	May		7-3	)		70	3/0	<u></u>	
1	1	Cothonine Pr	ALTERNATION AND ASSESSMENT		/						. 0		
4		Catherine B		100		Center	Blvd.	#20	3 Dunki	rk, Mar	yland	20754	
	State	31. Date filed (Month, Dey, Yeer)	***	Registrar's Signa	ature	4 1	20.11	,					
	Registrar	MAK	A LUUU	1	/	- lot	CULLES!						



Ammend #1 (Lane Calvert Co. Hea		ase Type or	Print In I						_	ble.		
04/06/00			or many ran		tificate				Reg. No.	00	11613	
	1. Decedent's Name (First, Midd							2. Date of D	eath		3. Time of Death	
Physician /Medical	Ashley Lanet	March	23, 200	O Year	8:20 P.M.							
Examiner	4a Fecility Nama (Minot institution	Town, or Lo	cation of Dea			1						
	2075 Plum Poir	nt Road			Huntingtown Calvert							
Funeral Director	5. Social Security Number 219–17–7512	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 12	last birthday) Yrs.	If Under 1 Y Months Do	ear If Unde eys Hours	er 24 Hrs. Min.	8. Dete of B (Month, D Sept.	9. Birthpleca (Steta or For Country) 17, 1987 West Virgin			
¥	Usuel Residence of Decedent  10a. State 10b. County	,	10c G	ty, Town or Lo	eation						Od. Inside City Limits	
vith the Marylar or 28a-f show be notified at Director				ntingto		4.			1 ☐ Yes			
5 a 4 W	2075 Plum Poir	at Pond			20639				10g. Citizen of United			
ther death viner death viner death viner must	11. Marital Status		edeni Evar in U	IS 13 V	Ves Decedent		Origin? (Spe	ecify Yes or N		ca - Americ		
5-0020 72 hours after of her steal Examiner	1 Never Merried 2 ☐ Mer	Armed F	orces? 2 100 ive		Yes, specify €	Cuban, Mexic	an, Puerto	Rican, etc.)		ck, White,		
Parties be		100,010	Jalas.	16a Deced	ent's Usuel O	ccupation	-		16b. Kind of B			
1121 within the Man	(Specify only higher Elementery/Secondary (0-12) None						ost of worki	ing	N/A		andony	
and 2	17. Father's Neme (First, Middle,	Last)				18. Mot	ther's Neme	(First, Middle	e, Meiden Sumer	ne)		
ylan ylan Mental Mental aric ev	Jonathan M. Sl	neldon, S	r.			Nane	ette (	Gale C	hurchill	1.31		
, Maryla and 2 should salth and Man 27 is marks or traumatic.	19a. Informant's Name/Relationship (Type, Print)  Nanette Sheldon (mother)  19b. Mailing Address (Street end Number or Bural Boute Number, City or Town, Stete, Zip Code) 2075 Plum Point Rd., Huntingtown, Maryland 20639											
Baltimore, semit, Pages 1 ar Jepannen of Hea mportant if New Imperiant if New International Internat	20a. Method of Disposition  1 Burial 2 Cremetion  4 Donation 5 Other (S	1 Burial 2 Cremelion 3 Removal from State 4 Donation 5 Other (Specify)  Lee's Crematory March 24, 2000 Clinton, Maryland										
Balti permit. Departi Imports any into	21. Signature of Funeral Service	Licensee			Name end Ad		Te		ral Home ings, Ma		vert, P.A.	
	23a. Part1. Enter the disease, or shock, or heart leilure. List	complications that	caused the deet								Approximate Intervel Between	
Physician										7	Onset and Death	
/Medical Examiner	Immediete Cause (Final disease or condition resulting in death)	a pul	Due to (o	ry 1	remor	rhag	e				6 days	
6		<	Due to (d	or este consequ	uence ot):	<					13	
n and isl-transit		b. 30				. 24	nds	and		-	10 years	
owed in and falter	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and religirator, page 2 should be detached for use as the burial-transit: To Be Completed by Physician/Medical Examir:	Cause (Disease or Injury that Initiated events resulting in death) Last  Due to (or as a consequence of):											
Box ( sath certif for use a										t		
cords, P.O. Box requires that the death cer been signed by the attending should be detached for use leted by Physician/N	Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying causa given in Pert I.								23b. Did tobacco use contribute to the cause of death			
cords, Frequires that been signed should be del eted by P								24a. We	s en eutopsy ormed?	av	ere autopsy tindings eilable prior to	
Reco								10	Yes 2 No	of	mpletion of cause death?	
f Vital Re	25. Was case referred to medica					26. Pla	ce of Deeth	(Check only				
Of Vita Physician: rithis certific vial director,	examiner?	Hospitel: 1 🗆	Inpatient 2	ER/Outpatient	3□ DOA	Other			idence 6 Ott	ner (Specil	y)	
Affer fune	27. Manner of Death  1. Netural 5 Pendir 2 Accident investi	24	of Injury oth, Day Year)	28b. Tima of Injury		Injury at Work? 1 🗌 Yes 2 🛭		28d. Describe	how Injury occur	rred	30000	
Division at or Attanding s after death. If Director: After ed in by the fune	3 ☐ Suicide 8 ☐ Could 4 ☐ Homicide determ	3 Suicide 8 Could not be 28e Place of Injury - At home Jarm, street							ation (Street and Number or Rurel Route Number, or Town, Stete)			
Division Complete Division of To the Hospital or Attanding Patch 124 hours after death. To the Funeral Director: After templetely filled in by the funeral Medical Certification:	29e. Cartifier in Certifyin (Check only ane)	g Physician: To the Examiner: On the b and men	best of my kno easis of examine ener steted.	wledge, death tion and/or inv	occurred at the	e time, dete e ny opinion, de	end place, e	end due to the ed et the time	cause(s) end m , date end piece,	anner as s and due to	tated. o the cause(s)	
To the within 2 To the comple	29b. Signature and title of certifie		,		29c. Lic	ense number	r		29d. Date signe	ed (Month,	Day, Year)	
	Exther	9.40	hus	nu	D 3	4605			March 2	24, 20	000	
6	30. Nama and address of person Esther Johnso					nd Blv	d., D	unkirk	, Maryla	and 2	0754	
State Registrar	31. Date filed (Month, Day, Year)	2 7 2000 1	Registrants Signa	iture	6. 1	parks	v					

DHMH 16 Rav 6/95

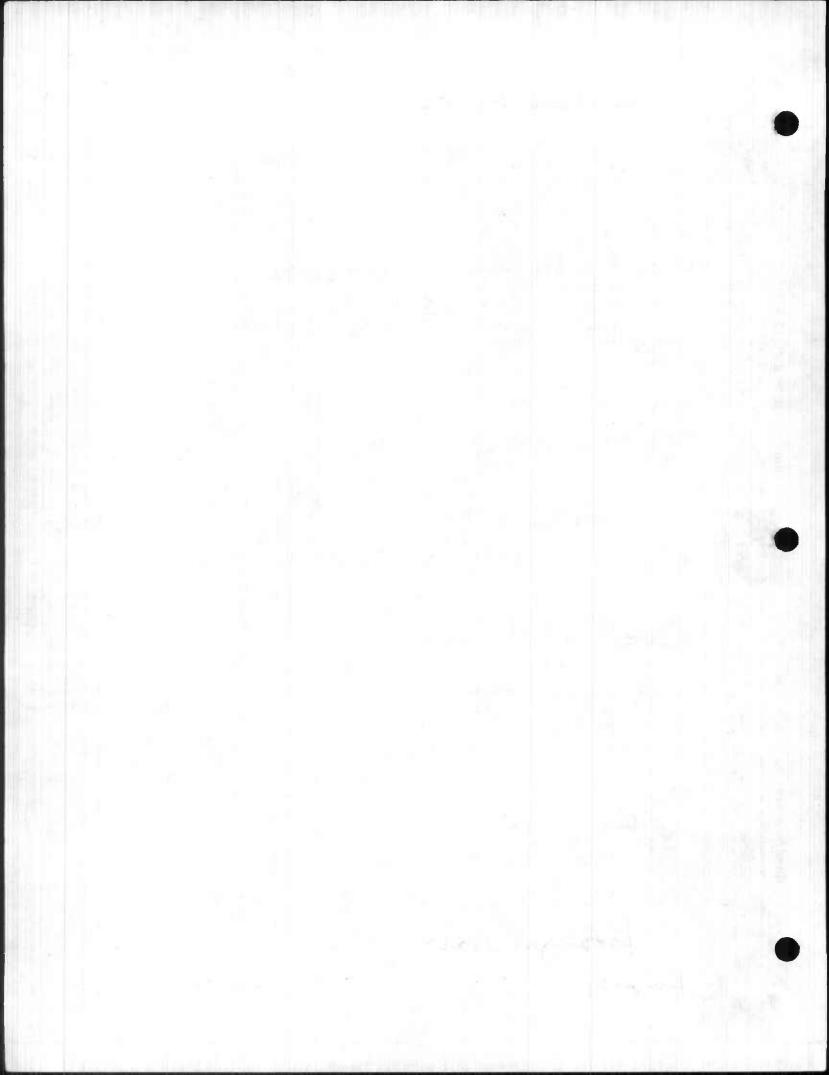


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 138 **Physician** WILLYAM BLAKE SHELTON LARC n21 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Baltimore stems altimore Medica If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□ F 220-55-2939 Director Oct. 25, 1999 4 25 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location ma 23a or 28a-f ahow 10d, Inside City Limits MD Washington County Hagerstown 1⊠ Yes 2 No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or 1740 Howell Road 21740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Hasth and Martel Hygiens. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Hed and Egypter Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 N/A N/A 17 Father's Name (First Middle | ast) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 David R. Sullivan Lisa A. Shelton 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa A. Shelton/Mother 1740 Howell Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rose Hill Cemetery Mar.25 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Kleucha 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner ettending physician and for use as the burlei-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detact 1 Yes 2 No 3 Probably 4 Unknown Records. by Be Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide edical Decertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature ar d Mile of certifies 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Beltimone Welbers 31. Date filed (Month, Day Year) State MAR 2 9 2000 Registrar

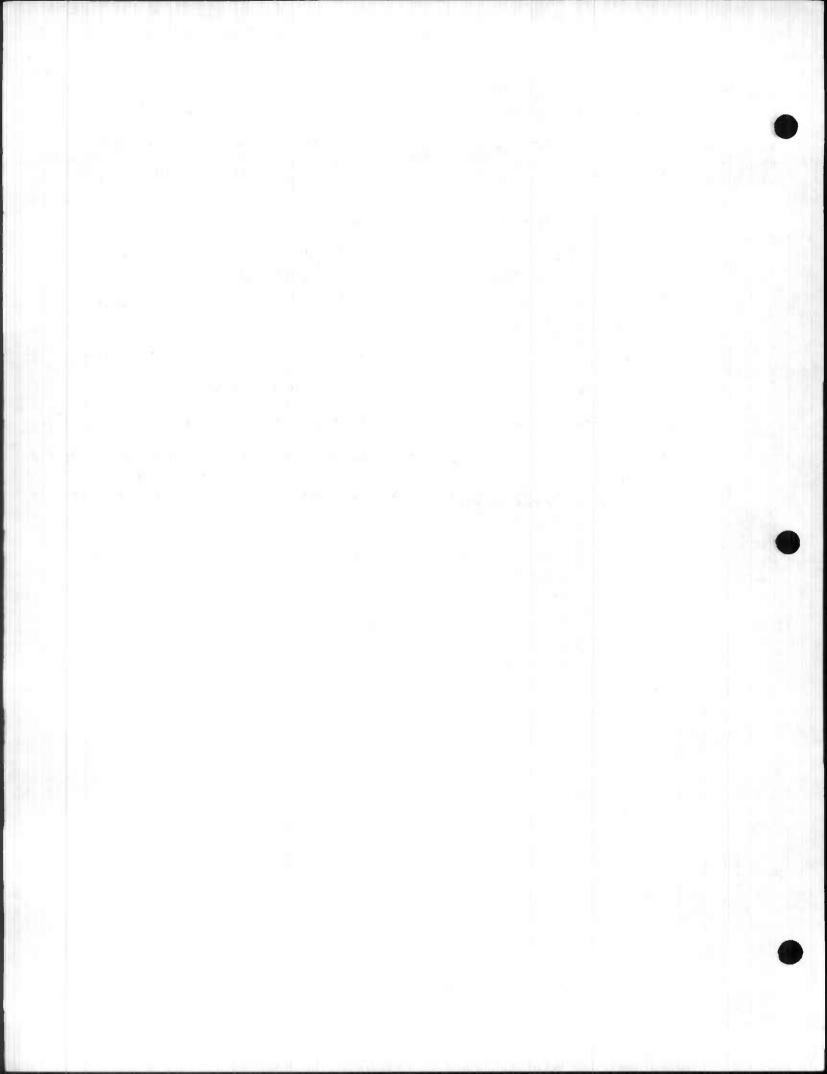
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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Baltimore,	permit. Pages 1 and 2 should Department of Health end Men Important: If item 27 is marke any injury or other traumatic ance.		20e. Method of Disposition		000	ce of Dispo	sition (Neme	of			Dete	20c. Location -	City or Tow	m, Stete	
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Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Henry Taylor March 30 2000 11:05 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1₩ 2□ F Months Yrs. Director 218-24-5104 Aug 28,1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Maryla must be notified at 1 ¥ Yes 2 □ No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 Barns 23s Funeral 124 N Main St 21639 USA 14. Race - American Indian, 12. Was Dacadant Ever in U.S. Armad Forces? 1 0XYss 2□No 1940— If Yes, Give Yeer or Dates: 1964 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, etc. the Medical Examiner 72 hours after 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Etementery/Secondery (0-12) College (1-4or 5+) Naval Officer Navy 4 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental My important: if them 27 is marked other any Injury or other to-17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 88 Levin Williams Taylor Ruth Plummer 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Taylor/ son 10008 W Franklin St Richmond, VA 23220 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State April 1 X Burial 2 ☐ Cramation 3 ☐ Removel from State 4 Donation 5 Other (Specify) 2,2000 Greensboro Cemetery Greensboro, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home PA 23a. Part 1. Entar tha disease, or complications that cause that death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. 21639 Approximata Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Mygeor Examiner Due to (or es e consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 edical Due to (or as a consequenca of) Physician/Me P.O. signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à Completed 24a. Was an autopsy 24b. Wera autopsy findings available prior to completion of cause of death? performed? has page 1 ☐ Yes 2 2100 1 Yes 2 No certificate Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2000 After this 28c. Injury at Work? 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 STNatural 5 Panding investigation Injury after death.

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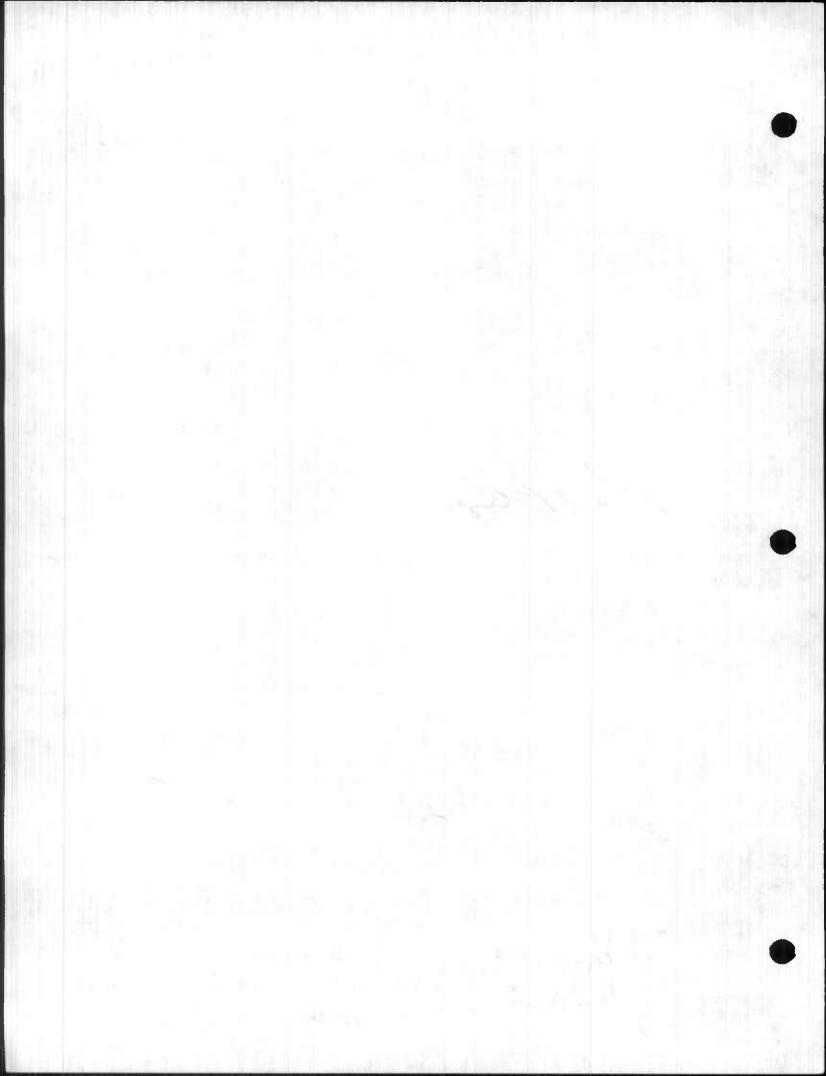
200 32. Registran's Signature

claster mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, DAP)

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month Day Year HAZEL MAE TAYLOR 050 27 2000 MARCH /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Sirth (Month, Day, Year) MAY 3, 1911 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign **Funeral** Days 1 M 2 XF Country) MARYLAND 212-72-1672 Vire 88 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND WICOMICO DELMAR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8662 DORIS STREET 21875 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 ss 1 and 2 should be flied within if Health and Mental Hygiene. Item 27 is marked other than "n Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Maryland 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) JAMES WILLIAM HARRISON LULA LAVINIA Pages 1 and 2 should 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARGARET KIRWAN/DAUGHTER 8662 DORIS STREET, DELMAR, MD 21875 Baitlimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Department of I 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 8 4 ☐ Donetiop 5 ☐ Other (Specify) WICOMICO MEMORIAL PARK 13/29/00 SALISBURY, MARYLAND 21. Signature neral Service Ligense 22. Neme end Address of Fecility ZELLER FUNERAL HOME, P. O. BOX 3171, en 1212 OLD OCEAN CITY ROAD, SALISBURY, MARYLAND caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, each line. Pert). Enter the diseese, or complications that shock, or heart failure. List only one cause of Approximete Interval Between Onset and Deeti **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical onces Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as e consequence of): Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of geath? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed by of Vital Records, pital or Attending Physician: The law requires tours after death. eral Director: After this certificate has been signs filled in by the funeral director, page 2 should be 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy ovan Cen 1 Yes 2 No 1 ☐ Yes 2 ☒ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Natural 2 Naccident Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) whice.

Registrar

State

30. Name and address of person w

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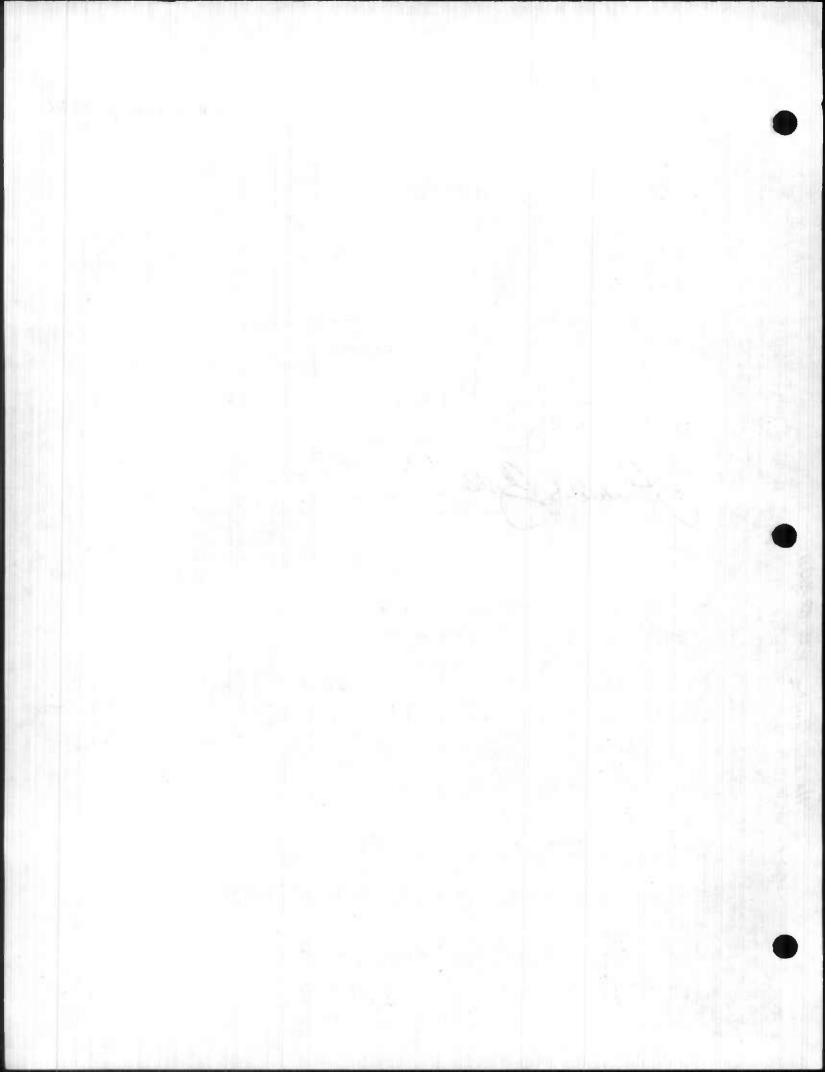
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to completed cause of deetre (item 23a) (Type, Print)

32. Registrer's Signeture

MAR 2 9 2000 >



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death March 27, 2000 TOWERS JOHN 0. 1515 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3739 Federalsburg Highway Federalsburg Caroline If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Deys Hours 10 M 20 F Months 65 Yrs. 217-30-9169 Jan. 15, 1935 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location t0d. inside City Limits Caroline Federalsburg MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3739 Federalsburg Highway United States 21632 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Nes 2 No If Yes, Give Year or Detas: 1 Never Merried 2 Merried White 1 ☐ Yes 20(No Specify: 3 ☐ Widowed 4 ☐ Divorced 157-59 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nylon Manufacturing Supply Clerk 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pauline Andrews George A. Towers 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip CodeN D 2 1 6 3 2 3739 Federalsburg Highway, Federalsburg, Doris H. Towers/Spouse 20b. Plece of Disposition (Name of cametery, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete Hill Crest Cemetery 4/1/00 Federalsburg, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Framptom-Hawkins-Eskow Funeral Home, PA Iskow PO Box 43, Federalsburg, MD 21632 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete ntervel Batween cell (accurry Immediata Cause (Finel diseese or condition resulting in death) Dua to (or as e consequenca of): Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Mo 3 Probably 4 Unknown

**Physician** /Medical Examiner

physician and s the burial-transit

that the death certificets be asscuted

Box 68760.

Division of Vital Records, P.O.

Hospital or Attending Physician: The law requires to hours after deeth.

Funeral Director: After this certificate has been sign.

24 hours 6

To the Hosp within 24 ho To the Fune completely fi

Be

Certification: To

Medical

State Registrar

**Physician** 

/Medical

Examiner

10a. Stete

**Funeral** 

Director

28a-f show must be notified at

"natural", or harms 23a or

Hygiene. ther than

permit, Pages 1 and 2 should be file.
Department of Health and Mental Hy important! If New 27 is marked other any Injury or other to

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

Examiner Sequentially list conditions, if any, leeding to immadiete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical þ Completed

24b. Were eutopsy findings eveilable prior to completion of cause of daath? 24e. Was an autopsy performed' 1 Yes 2 No 1 Yas 2 No 25. Was casa ratarred to medical axaminer? 26. Place of Deeth (Check only ona) 1 Yas 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (DiNetural 5 Panding 1 TYes 2 TNo investigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, atc. (Specify) 4 Homicide

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledga, daeth occurred at the time, date end place, and due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

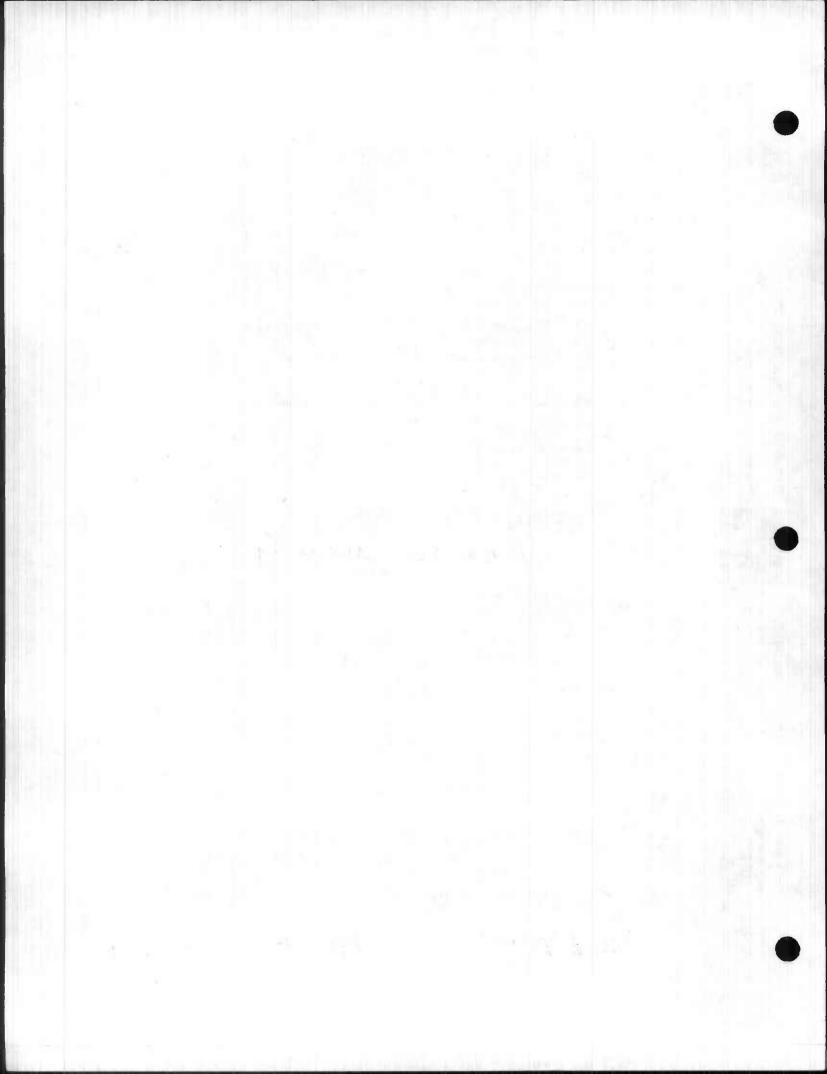
Pintail Drive, Easton, MD 21601 29466 David Smith, M.D.

31. Date filed (Month, Day, Year)

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32. Registrer's Signeture

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Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

virity fours after death. Page 6 may be retained by the hospital or attending physician.	actor, page 5 should be detached for use as the burial-tran		must be notified at once.
r death. Pag	ne funeral di	al.	examiner
yours afte	filled in by the	on, or remov	ne medical
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ATTENDING PHYSI	RECTOR: After this c	rs after death with	m 28 is marked,
TO THE HOSPITAL OF	TO THE FUNERAL DIF	be filed within 72 hou	IMPORTANT: If Itel

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31. DATE FILED (Month, Day, Year)

MAR 2 4 2000

11619 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATN 3. TIME OF DEATN 2000 YEAR March 23, Lovealene Lorraine THOMPSON 12:20 a.m.m 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS 220-28-8691 1 M 2 F 67 Jan. 15,1933 Maryland 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 236 Winter Street Hagerstown Washington RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Washington Hagerstown 1 X YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 236 Winter Street 21740 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried If yes, specify Cuben, Maxican, Puerlo Ricen, etc.) IF YES, GIVE WAR OR DATES Specify: white 1 TYES 2 NO Specify BY 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 10 homemaker her own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Samuel Keller Nannie Montgomery BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William B. Thompson - husband 236 Winter Street, Hagerstown, Maryland 21740 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify) \_\_ Cedar Lawn Memorial Park 3-25-00 Hagerstown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Death disease or condition nont resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 HO DF DEATH? 1 TYES 2 TNO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 □ Inpetient 2 □ ER/Outpetient 3 □ DOA OTHER: 1 TYES 2 DATE 4 Nursing Nome 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED 1 Matural 5 Pending Investigation ВҰ 1 YES 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, lectory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 1 CERTIFYING PNYSICIAN: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner ee atsted. (Check only one) 2 MEDICAL EXAMINER: On the basis of and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as atated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Geneva

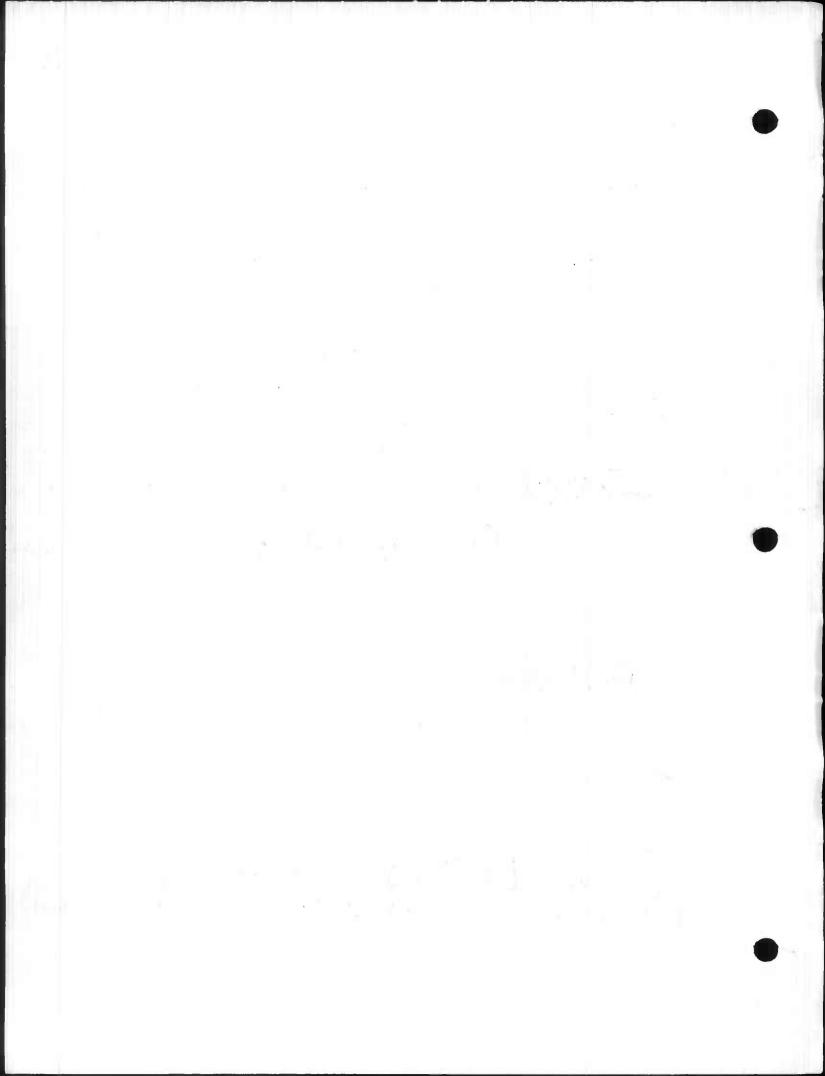
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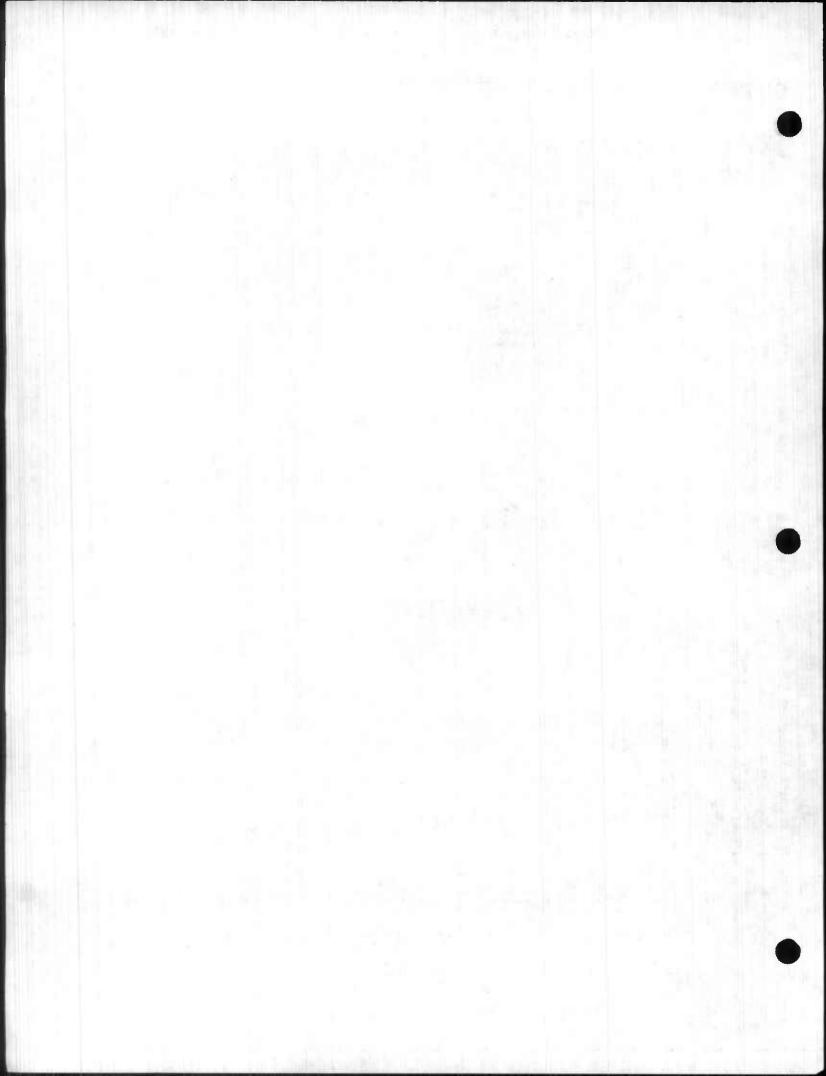


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

11620

Use after death with the Maryland // Wedical // Wedical Examine Examine Director   Factor of the modified   Factor of the	4a Facility Name (If not institution, given Washington Count 5. Sociel Security Number 6. S.	ve street and number)  Ly Hospital  Sex 7. Age (In yr.	s. last birthday)		4b. City, Town, or Lo Hager		26 20			
Examine Funeral Director	4a Facility Name (If not institution, gh Washington Count 5. Sociel Security Number 167-22-5532 Usuel Residence of Decedent	y Hospital Sex 7. Age (In yr.	s. last birthday)		Hager		4c. County			
Director	5. Sociel Security Number 6. S 167-22-5532 Usuel Residence of Decedent	Sex 7. Age (In yr	s. last birthday)	WID- 4 4 V		SCOWII		4c. County of Death Washington		
ith the Maryland or 28a-f ehow		/	1 Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthplece (State or Foreign Country) Pennsylvania		
ith the Maryla or 28a-f ehov		Len	Oh. Tour cal	-tion						
or 28			City, Town or Loc Hage	rstown				10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
	10e. Street end Number			10f. Zip Code		10	g. Citizen of V	/hat Country?		
23a	11518 Green Valle	ey Drive			21740		USA			
if, or hema		12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Yeer or Detes:		Vas Decedent of H Yes, specify Cube	dispanic Origin? (Spe en, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e-American Indien, k, White, etc. : white		
natural, rdical Exp	15. Decedent's E	ducetion	16a. Deced	ent's Usual Occup	pation	10	6b. Kind of Bu	siness/Industry		
	(Specify only highest grant Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)			during most of worki	ing				
4	12	0	S	ales cle			department			
atic even	17. Fetners Name (First, Middle, Last				18. Mother's Name Edith Al			e)		
EE	19e. Informant's Name/Relationship (				and Number or Rure			State, Zip Code), Md. 21740		
ther the	20a. Method of Disposition		Plece of Dispos	sition (Name of				City or Town, State		
Important: If item 27 le any injury or other treu pncs.	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crem	1 Cemete				town, Maryland		
- Indi	21. Signeture of Futing at Service Lice		-	Name and Addre	-			RAL HOME		
E CO	16det	- / //		415 E.W	ilson Blv					
certificate be asscuted adding physician and use as the bunal-transit		C	(or as a consequ							
		contributing to death but not re	esulting in the un	derlying cause giv	ven in Part I.	23b. Did tob	pacco uae coi	ntribute to the cause of death?		
detach	malignant	n·	1 Yes 2 No 3 Probably 4 Unkn							
cate has been signed by the atten ; page 2 should be detached for u			24a. Was an autopsy performed?  24b. Were autopsy fi available prior to completion of cidenth?							
te ha						1 □ Yes	5 20 NO	1 ☐ Yas 2 ☐ No		
s certificate has director, pege 2	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one	9)			
0 0	1 Yes 2 No		☐ ER/Outpatien		4 U Nursing Ho	me 5 Resider	nca 6 DOth	er (Specify)		
After funer	27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	ry at rk? !Yes 2 □ No	28d. Describe how	w injury occur	red		
of Director: After the director of the funeral control of the funera	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Str. City or Town,	eet and Numb , State)	er or Rural Route Number,		
		nyelclan: To the best of my ki miner: On the basis of exami								
Euna Funa Itely i	WII.	and manner stated.	1 10	29c. Licens	se number	29	d. Date signe	d (Month, Day, Year)		
o the Funer completely fil	29b. Signature and title of certifier									
offin all	29b. Signature and title of certifier	MAG	/111	DH	6473		3/26	100		
To the Hospital within 24 hours To the Funeral completely filled	29b. Signature and title of certifier  30. Name and address of person who	completed cause of death (It	em 23a) (Type, I	DH Print)	6473	. 10	3/26	100		



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer Month Workman Richard 2135 March 2000 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Calvert If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) DC 7 Washington 5. Sociel Security Number Date of Birth (Month, Day, Year) Days 1□ M 2□ F Yrs. 578 48 9175 Sept 11 1937 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 Laurel Drive 20657 United States 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Yeer or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Giant Food 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Roland Joseph Workman Helen Cecelia McCambridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Koehn- daughter Box 428 St. Leonard MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral 20a. Method of Disposition 20c. Location - City or Town, State Dete 24 2000 Servicelexandria 1 Burlal 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Virginia 22. Name and Address of Facility ure of Funeral Service License Rausch Funeral Home PA O 4405 Broomes Is. Rd. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Conpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /iviedicai Examiner The law requires that the death certificate be executed burial-trans Box 68760.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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23a

hours afte

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of Health and Merial Hygiene.
If them 27 is merked other thus or other transmission

Department of I Important: If its any injury or of

Pages 1 and 2 should

Maryland 21215-0020

altimore,

P.O.

Records,

Division of Vital Attanding Physician: Funeral

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Completed

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use as the signed by the page 2 should certificate this funeral After spital or Attandin cours after death. weral Director: Aft filled in by the fur

Physician/Medical Examiner þ Be Completed Medical Certification: To

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one) 29b. Signature and title at

4 Homicide

30. Name and address

5 Pending investigation

6 Could not be determined

State Registrar

within 24 hours a To the Funeral I To the Hospital

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) 2000 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Prin

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 | Yes 2 | No

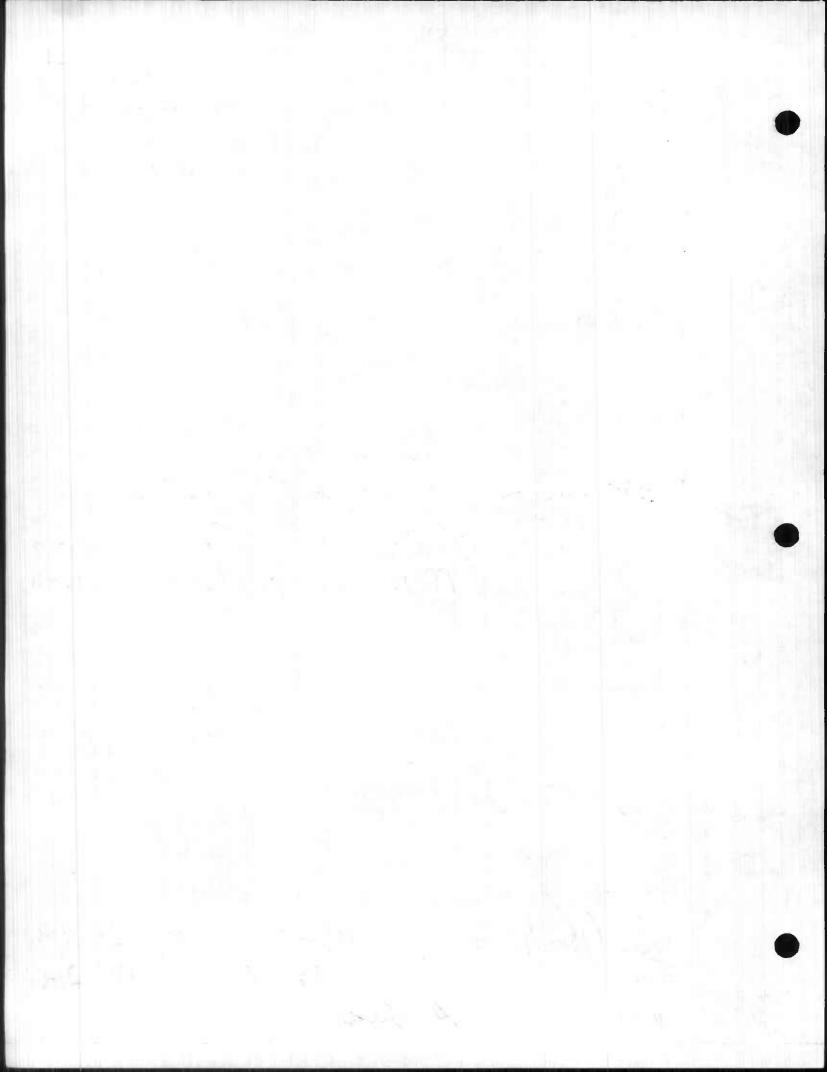
29c. License number

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

281. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) Month **Physician** Martha Bitner Wolfinger 3:00 PM 0 22 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington Hagerstown If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Months Days Hours 198-30-4447 87 Yrs. 3. Penna Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or flams 23s or 25s-1 show the Medical Examiner must be notified at PA. Franklin Greencastle 1 X Yas 2 □ No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 261 Apple Dr. 17225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status 1 Yas 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specity: White À 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) and 2 should be easth and Mental marked Harry Albert Bitner Florence Isabella Fletcher 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) artment of Health ar ortant: If item 27 is 5250 Valley Forge Dr. Alexandria, Va. 22304 Kathleen L. Wolfinger/Daughter Baltimore, 20b. Place of Disposition (Neme of cemetery, crametory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ! 8 1 Burial 2 Cremation 3 Removal from State 3/26/2000 Cedar Hill Cemetery Greencastle, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. H. Monte merio 17225 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Physician Immediate Causa (Final disease or condition resulting in death) /Medical 24 428 Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Box 68760, Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? Anterioscherotic Heart Disease 1 Vea 2 No 3 Probably 4 Unknown this certificate has been signed by of Vital Records, Medical Certification: To Be Completed by 99 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Por cure Sortic Onlue funeral director, page 2 should 1 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pe 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1 Hatural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital e within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Wedowhaker 007885 3-22-2000 wis 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Dey, Year)
MAR 2 4 2000

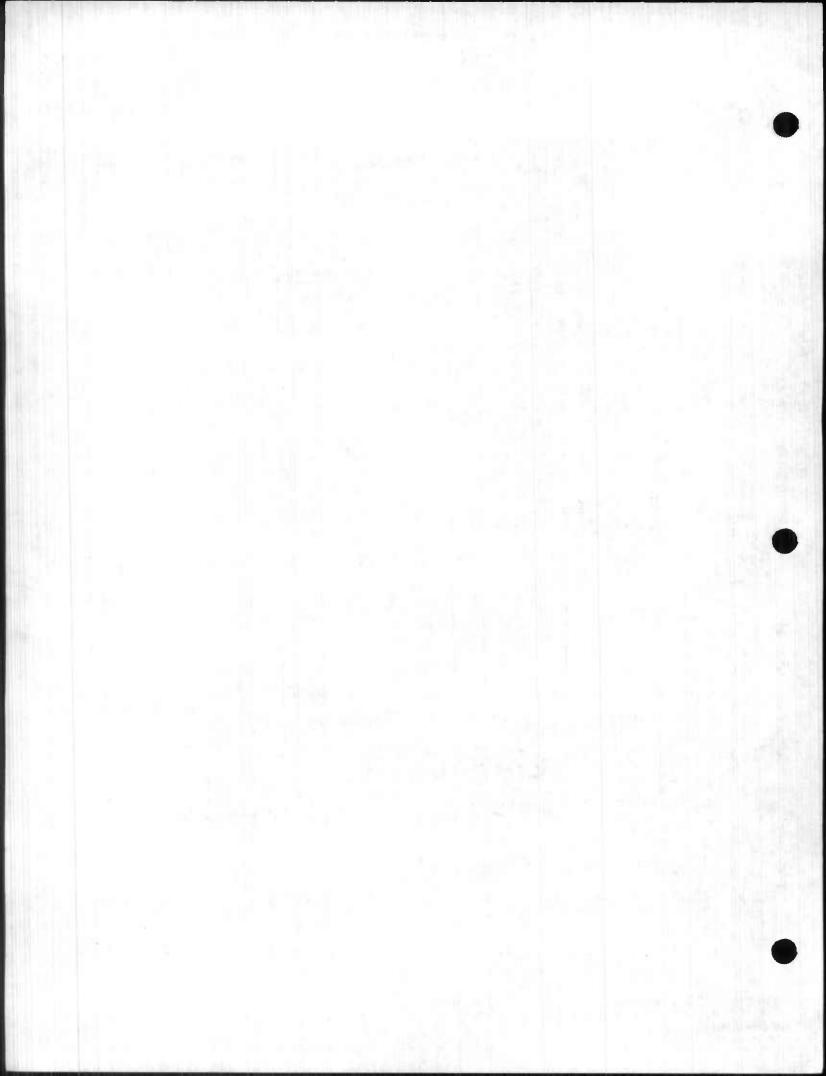
John Hornbaker, MD.

32. Registrar's Signature

11110 Medical Campus Dr. Hagerstown, Md. 21740
s Signature

A. Apark

Wolfinger,



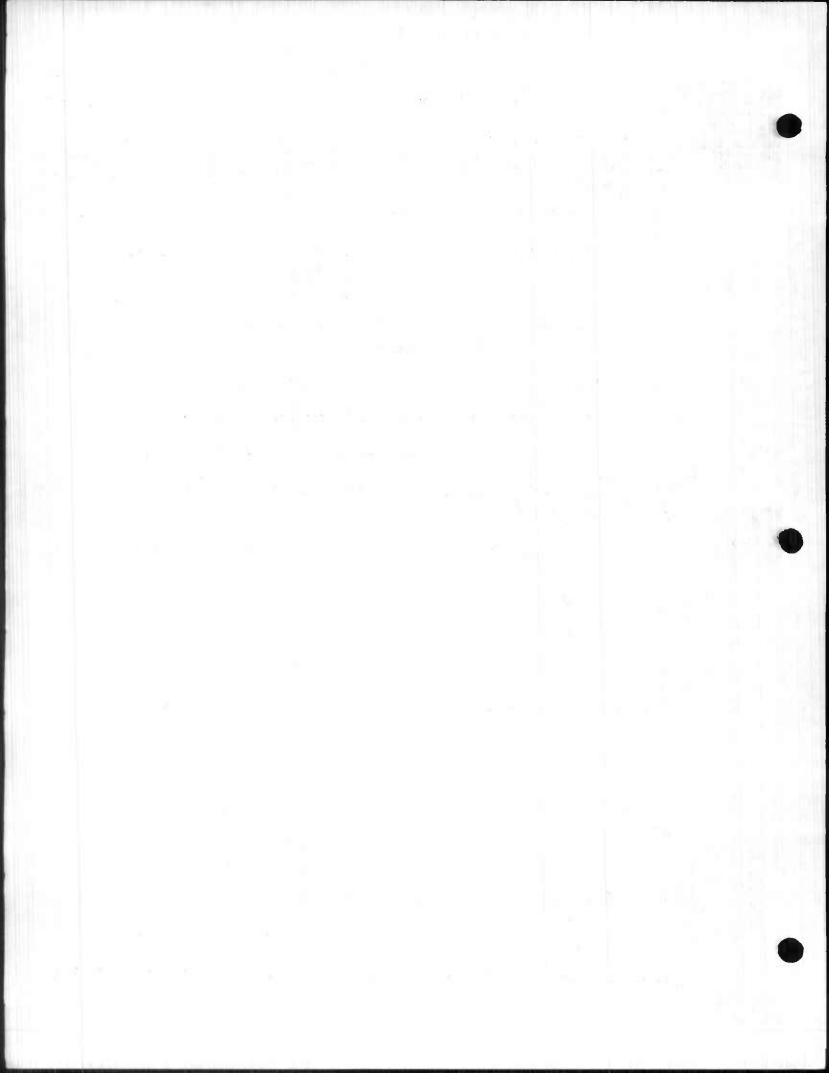
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth March 24,000 ear **Physician** Charlotte Mae Willard 12:05 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7835 Mt. Laurel Rd. Boonsboro Washington tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Teb. 26, 1918 West Virginia 5. Social Sacurity Number 6 Sex 7. Aga (In yrs. lest birthday) Birthpleca (Steta or Foreign Country) **Funeral** 1 M 2 SF 215-14-1768 Yrs. 82 Director Usuei Residence of Decedent the Maryland 10a State 10b. County 10c City Town or Location 10d. Inside City Limits r than "naturel", or items 23e or 28a-f show the Medical Exprising must be notified at Washington MD. Boonsboro Director 1 1 Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7835 Mt. Laurel Rd. 21713 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armad Forces? 1 ☐ Yas 2 ☒ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16e. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker home 17. Fethar's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John W. Miller Edith Mae Dopson 19e. informent's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Raymond A. Willard (Husband) 7835 Mt. Laurel Rd., Boonsboro, MD. 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State Mt. Zion Cemetery March 27, 2000 San Mar, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Runeral Service Licansee 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, MD. 21783 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Metastatiz infittrating duetal carrinoura of broast /Medical Immediate Cause (Final 415. disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner bunal-transit certificeta be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of) Box 68760. ettending physicien Physician/Medical the Due to (or as a consequence ot): 93 Records, P.O. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? signed by DIZENSE 1 Yes 2 No 3 Probably 4 Unknown ALZHEIMER'S þ 8 24b. Wera sutopsy findings avaitable prior to paga 2 should Completed 24e. Was en eutopsy Deed completion of cause of death? has 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics complately filled in by the funeral director, i Be 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 10 1 Yes 2 PNo 27. Manner of Deeth 28a. Date of injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streat, tactory, offica building, atc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end dua to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end mannar stetad. Medicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa numbar TSON Who completed cause of deeth (Item 23e) (Type, Prim) ROESS USP WD PO BOX 17 WIDDLETOWN, WD. 21769 30. Name end eddress of perse JAMES L. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 4 2000 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene HENRY ALLEN Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 2000 Year **Physician** APRIL 4, 2017 PM homas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner BALTIMORE CITY 1617 LORMAN COURT 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2□ F Months Days Hours Yrs. 217-52-3753 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits BALTE 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 U.S.A. natural, or hams 23s DRMAN Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - American Indian Black, Whita, atc. I □ Yas 2 X No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1□ Yas 2⊠ No Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 Divorced SLACK Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) nd Mental Hygiene. marked other than INEM PLOMED 119 N 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Father's Nama (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental HLLEN TUSSELL 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number Department of Health and Important: If Hem 27 is m any injury or other traum QDSS. Salton 3623 Md. 21229 HARles + Emma Place of Disposition (Nama of cematary, cramatory or other place Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from State ansdownt come kry 21. Signators & Funeral Service Licensee 22. Nama and Addrass of Facility AKOLINE mD 26713 1129 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, book, or han failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical NARCOTIC AND COCAINE INTOXICATION **Examiner** Dua to (or as a consequence of) Examine be axecuted Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Dua to (or as a consequanca of): pue Box 68760. Physician/Medical Dua to (or as a consequence of) t e 83 23b. Did tobacco use contribute to the cause of peath? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 94 40 Unknown 1 Yes 2 No 3 Probably yd bengis by Records, 24b. Ware autopsy findings available prior to completion of cause of death 24a. Was an autopsy performed? Completed hes page 1 Yas 2□ No 2CI No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

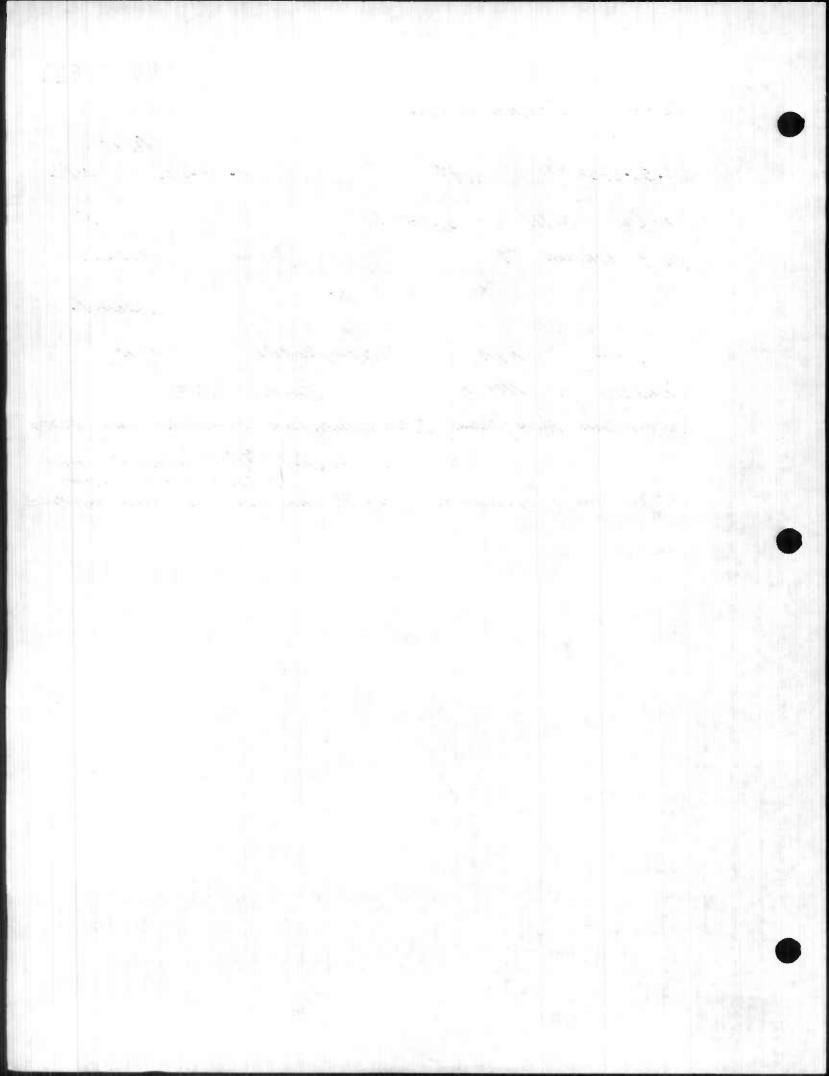
To the Funeral Director: After this certifica Be 25. Was casa refarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant Other: 4 Nursing Homa 5 Nasidanca 6 Other (Specify) To XX Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurredUNKNOWN P 28c. Injury at Work? Medical Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 5 Panding Invastigation found<sub>8:00</sub>M 1 Natural found 1 ☐ Yas 2 ᡯ No 2 Accident 4/4/00 6 ☑ Could not be datarmined 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1617 Lorman Court 3 Suicida 4 Homicida Baltimore, Md. found at home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and fittle of certified APRIL 5, 2000 OCME erson who complated cause of death (item 23a) (Type, Print) 30. Nama mn Tane(111 Penn Street, Baltimore, Maryland 21201 5

State Registrar

31. Data filed (Month, Pay, Year)

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death April 6, Day 2000 ear 11:34PM Luther M. 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Carroll County Golden Gate Guest Home Woodbine If Under 24 Hrs. 8. Date of Birth (Month, Day, )
Jan 23, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign N. Carolina 6. Sex 7. Age (In yrs. last birthday) 1XX 20 F Months Days 1913 N. Yrs. 216-01-1182 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore Mes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1024 W. 38th Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes YNO if Yes, Give X Yeer or Dates: 1 ☐ Yes X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Baltimore City Deputy Sheriff 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clifton Butler Bessie Ouick 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21211 1024 W. 38th Street, Baltimore, Maryland 19a. informant's Name/Relationship (Type, Print) Anna M. Butler Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 4/10/00 Woodlawn, Maryland Lorraine Park Cem 21. Signature of Emeral Service Liceds 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland Maryland Approximate Home of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Immediete Ceuse (Fina MUMMIN disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was cese referred to medical 26. Piece of Deeth (Check only one) examiner? Other: 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Naturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

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/Medical

Examiner

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Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

To the Mospital or Attending I within 24 hours effer death.

To the Funeral Director: After

State Registrar

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier lau

29c. License number 3076

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

29d. Date signed (Month, Day, Year)

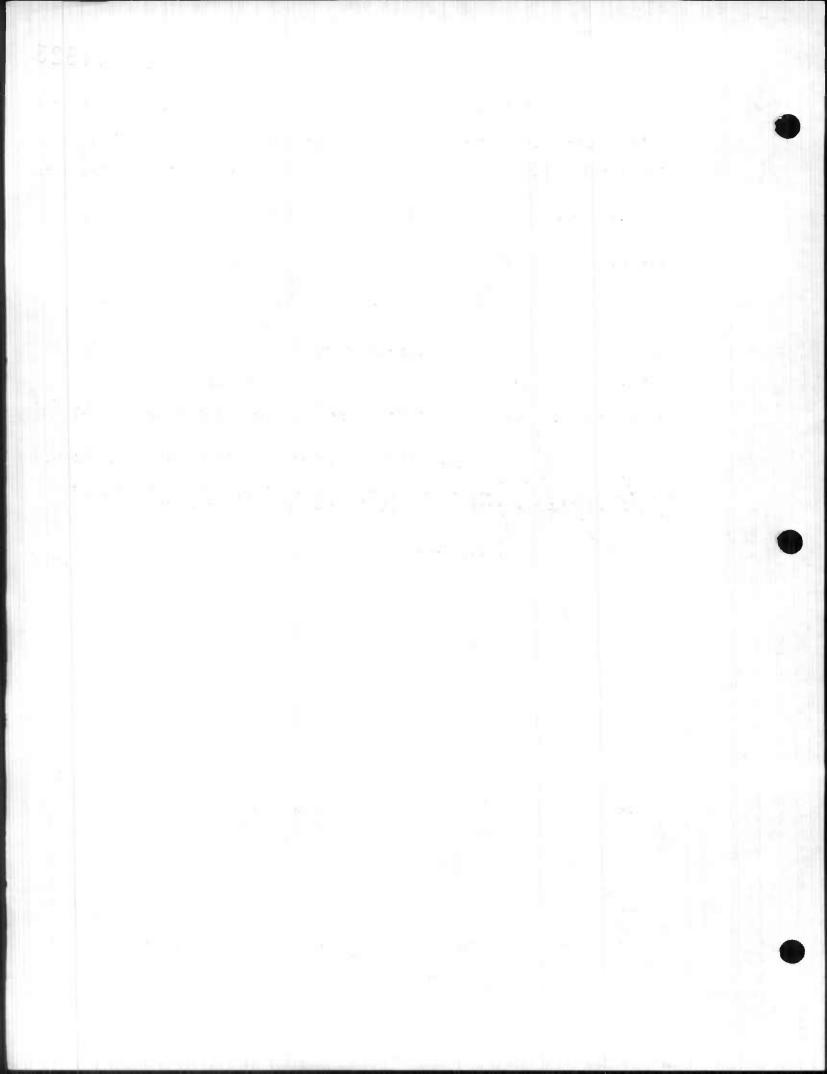
30. Name end address of pe completed cause of death (Item 23e) (Type, Print)

730 Falls Road

Baltimore, MD 21211

32. Registrar's S strar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 1. Decedant's Nama (First, Middia, Last) 2. Data of Death Day Year Month **Physician** Roseliu BAILER 9 = 4 OAM 4 2000 10 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORGST HILL Grojbon HALFOND SLUP 10 Hi Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) SEPT 16, 1 Birthplace (Stata or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1□M 25 F 577-03-0796 86 Yrs. Director Maryland Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Exerciper must be notified at 1 Yas 2 No Director Harford Forest Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21050 USA 2225 Grafton Shop Road Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 ☐ No Specify: Specify. by 3 Widowed 4 □ Divorced Yeer or Datas: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygles Important: if Item 27 is marked other th any injury or other traumatic avant, the page. Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be UNK. UNK. 19a. Informant's Name/Relationship (Type, Print)
Diane Allen/Caretaker 19b. Mailing Addrass (Street and Number or Rurat Routa Number, City or Town, Stata, Zip Code) 2225 Grafton Shop Rd., Forest Hills, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2X☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/11/00 Baltimore, MD 21. Signature el Eunaral Sarvice Licer 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. Thomas Gree 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final · CONGESTIVE diseasa or condition resulting in death) HEART PAILURE Examiner Due to (or as a consequence of): Examiner AL FIB MULATION physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadieta causa. Entar Underlying Cause (Disease or injury that initieted events rasulting In death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ∏Yes 2 Nalo Hospital or Attending Physician: Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending within 24 hours after death.
To the Funeral Director: Af 1 Yes 2 No invastigation 2 Accidant 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurat Route Number, City or Town, Stata) 3 Suicida 4 Homicida Medical 29a. Certifian 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. (Check only one) 25 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura end title of certifier

State Registrar

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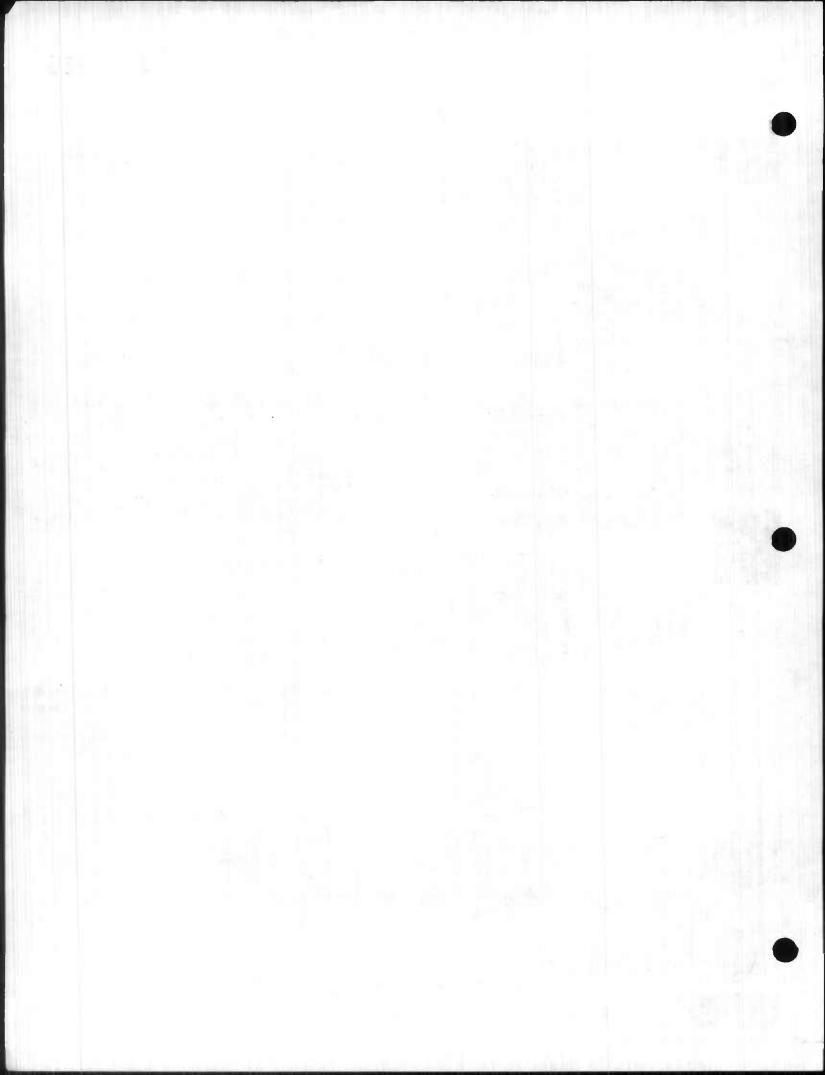
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

2000 32. Registrar's Signature

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31. Data filed (Month, Day, Year) APR 1



Examiner Box 68760 P.O. Division of Vital Records.

The law requires that the death certificate be executed

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/Medical

**Examiner** 

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Physician/Medical

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State Registrar **DHMH 16 Rev 6/95** 

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29b. Signatura and title of certifiar

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29c. Licensa number

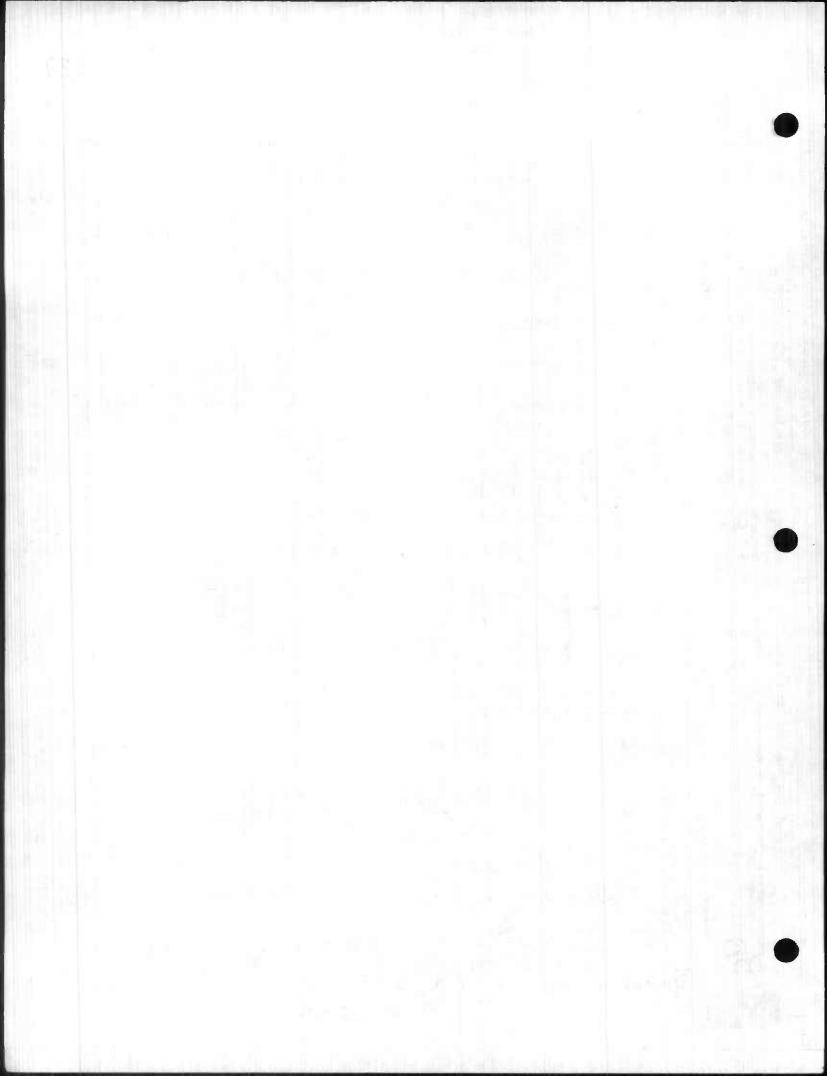
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29d. Date signed (Month, Day, Year)

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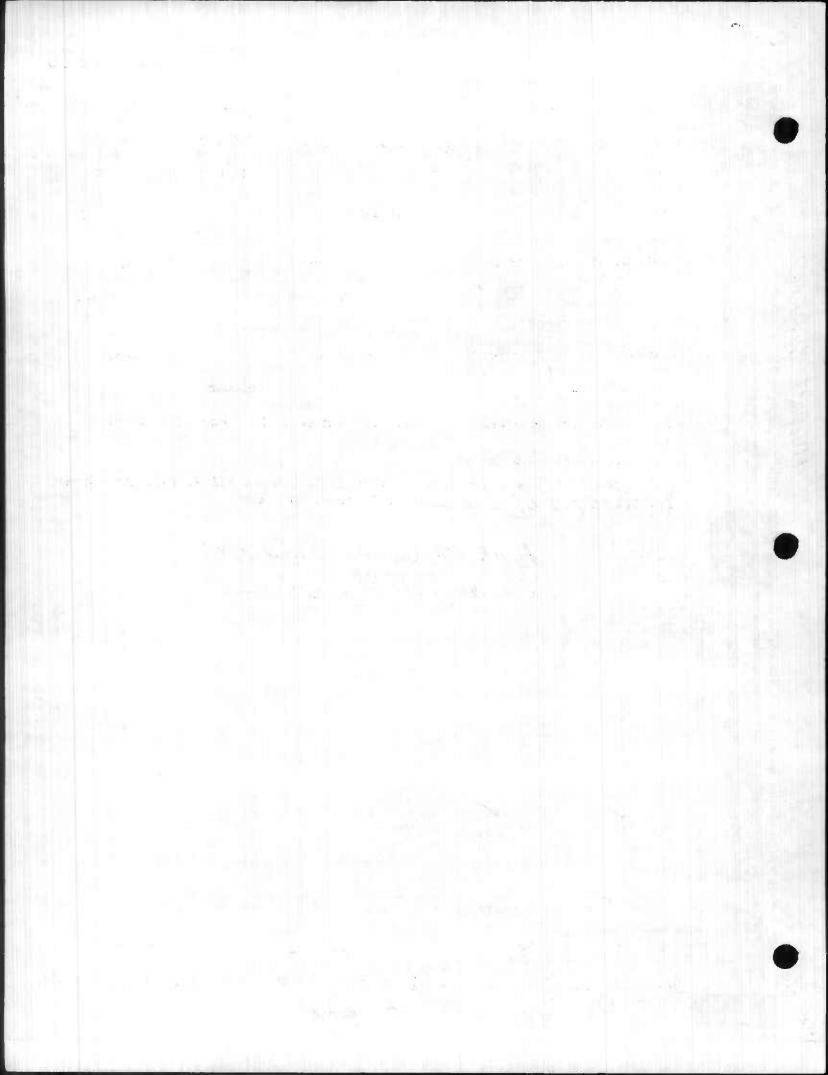
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BALTIMORE NO 21228



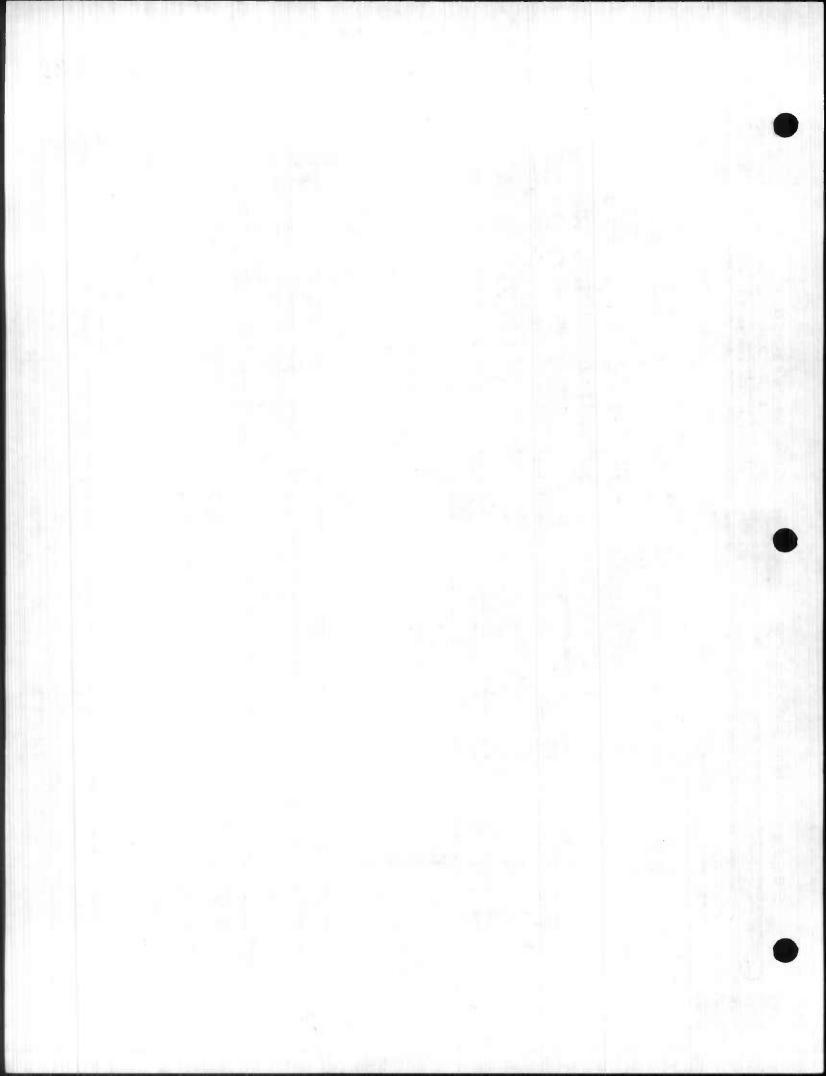
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Baltimore, MD 21201  22a Part. Enter the disease, or simplication of the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, interest Between Consett and Death Conset	injury	20a. Method of Disposition  1 Buriai 2 Cremation 3	Removel from State	ce of Disposition (N	ame of				ite
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25. Was case referred to medical examiner?  10 Yes 2 D No  27. Menner of Death Naturei 2 Accident 3 Sulcide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how Injury occurred  28d. Location (Street and Number or Rural Route Number of Town, State)  28d. Certifier (Check only one)  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Describe how Injury occurred  28d. Location (Street and Number or Rural Route Number of Town, State)  28d. Location (Street and Number or Rural Route Number of Town, State)  28d. Location (Street and Number or Rural Route Number of Town, State)  28d. Location (Street and Number or Rural Route Number of Town, State)  29d. Certifier (Check only one)  29d. Certifier (Check only one)  29d. Certifier (Check only one)  29d. Date signed (Month, Day, Year)  4/3/07	Comp					10	Yes 2000		
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30. Name and address of person who empleted ceuse of deeth (Item 23a) (Type, Print)	W W	29b. Signature and title of certifier	40	2	9c. License number		29d. Date signed 4/3/	(Month, Day, Y	ear)
Dinesh Macar, M.D. 40 Makyland General Hospital		30. Name and address of person who	empleted cause of deeth (Item :	23a) (Type, Print)	Ryland	Genera	al H	OSPIT	40



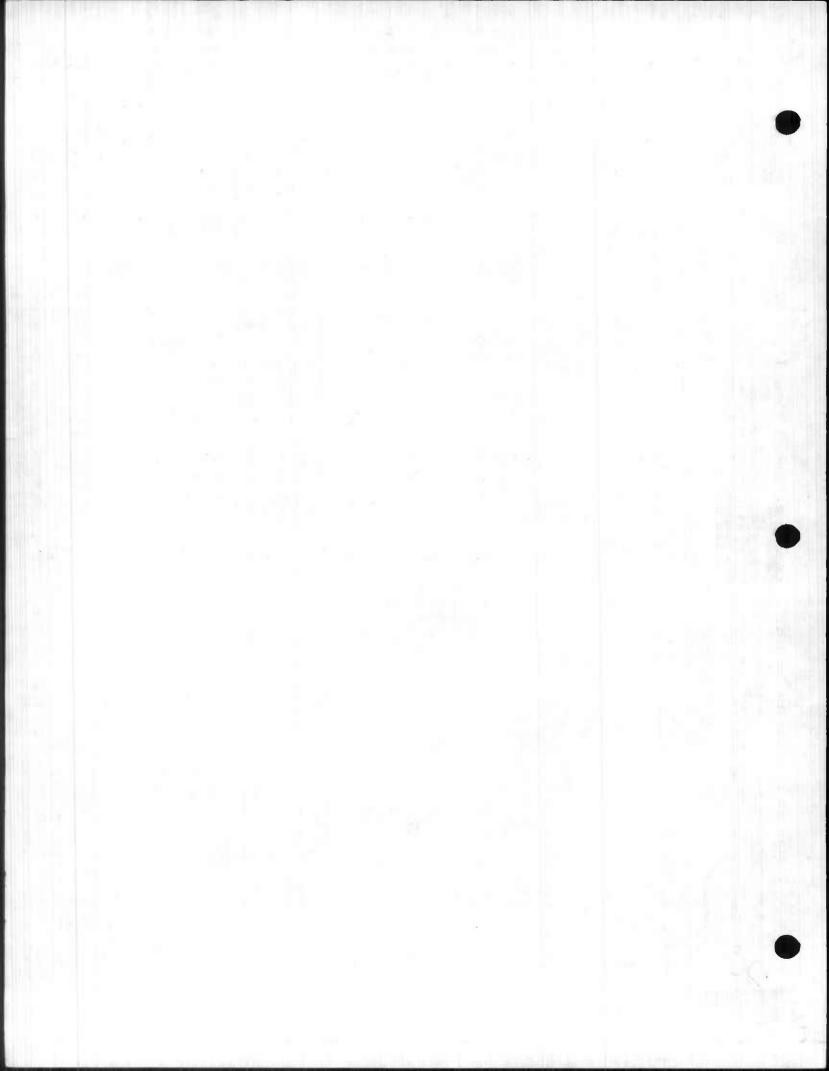
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Barbara Baker 6, April 2000 10:00 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8875J Tamebird Ct. Columbia Howard If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 10M 20F Yrs. 236-72-4928 53 Director Jan. 26, 1947 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at Columbia MD. Howard 1 ☐ Yes 2 No Director 'natural', or herne 23a or 25a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8875J Tamebird Ct. 21045 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: white 1 ☐ Yes 2X No Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) reservation specialist government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health end Mental H lant If Nem 27 is marked off Be Billie Brooks Prickett Hazel Elizabeth Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2.
Department of Health a Important If Item 27 is any injury or other trait 2008. Bradley Baker, son 8875J Tamebird Ct., Columbia, M d. 21045 20b. Piece of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore Washington Crem. 4/10/00 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signeture of Funeral Service Licenses 5555 Twin Knolls Rd., Columbia, MD 21045 Kemmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · Atheroscleratic Cardiovascular cars disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner pertension physicien end s the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events reaulting in death) Last Box 68760. ho est cvo Physician/Medical Due to (or as a consequence of) 88 P.O. | ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, sign be c þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 No 2 X No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Certification: To Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Netural 5 Panding investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide edical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier To the Hospi within 24 hou To the Funer completely fil (Check only Deput MB 29d. Date signed (Month, Day, Year) 29b. Signature and thie of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRYCE A. TOYE, MD 4505 Hemlock Cone Way Ellicott City MD 21042 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 20 PER F.H. G782 4-11-00 WR. Cortificate of Death Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** GEORGE R. BEHR 4 7 2000 6:53 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 14308 Lighthouse Ave. Ocean City Worcester If Linder 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Months 1**X** M 2□ F 216-24-6221 Yrs. Director 1/3/1929 MD Usuel Residence of Decedent the Marylend 10a. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MYes 2□ No MD Worcester Ocean City Director 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? with 14308 Lighthouse Ave. 21842 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 WWII 1 ☐ Yes 2 No Specify. Specify: white by "natural", 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional 12 Salesman other 18. Mother's Name (First, Middle, Maiden Surname) 17. Falher's Neme (First, Middle, Last) Be Peges 1 and 2 should be nent of Health and Mental int: If Hem 27 le marked or Henry H. Behr Margaret Pfeffer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14308 Lighthouse Ave. Ocean City, MD 21842 Patricia M. Behr/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or poce. 4 □ Donation 5XX Other (Specify) ENTOMBMENT Moreland Memorial Park 4/10/00 Baltimore, MD 21. Signalure of Funeral Service Licensee Paul L. Hartsock, Jr. 22. Name and Address of Facility Baltimore, MD 21214 Hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. an 5305 Harford Rd. 23a. Pert1. Enter the disease, or complications shock, or heart feilure. List only one cads Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Finel disease or condition resulting in death) obstructed pulsorry /Medical Examiner The law requires that the death certificate be executed **burial-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequenca of): physician Box 68760 Physician/Medical the Due to (or es e consequence of): for use as 980 P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 1 1ss 2 No 3 Probably 4 Unknown Records. p 24b. Were eutopsy findings available prior to Completed 24a. Was an eutopsy performed? peed completion of cause of death? page 2 2 12 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Placa of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Affer 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) after 4 Homicide within 24 hours after To the Funeral Discompletely filled in Hospital 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. (Check only one) within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) They SIC11-30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT J. DURKIN, D.M. RKIN 31. Date filed (Month, Day, Year) 32. Registrar's Signeture APR 11 Seper Registrar



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	Mariner Health of Forest Hill  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Y						If Under 1 Yeer		st Hill			
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The Function After this certificate has been signed by the attending physician and pletely filled in by the luneral director, page 2 should be detached for use as the burial-transit or properties in the luneral director, page 2 should be detached for use as the burial-transit or pletely filled in by the luneral direction: To Be Completed by Physician/Medical Examiner	Immediate Causidisease or condition rasulting in death rasulting in death seems of the course. Entar United Sequentially list if eny, leading to ceuse. Entar United Sequential seems of the course (Disease that initiated evar resulting in death resulting in death seems of the course	conditions, immadiate deriving or injury nits in the condition of the cond	d d.	spitel: 1 Ir 28a. Date o (Montre building)  26e. Place building  tan: To the bar and manner  pleted ceuse	Due to (compute to	or as a consector as	quence of):  quenc	26. Place of Dither: Nursing ury at ork? Yes 2 No	23b. DI 1[ 24e. Wippe 1[ Home 5 Ra 28d. Describ 26f. Location City or 7	d tobacco use compared?  Yes 2 No es an autopsy normed?  Yes 2 No es an autopsy normed?  Yes 2 No es an autopsy normed?  (Street and Numown, Stete)  Is cause(s) and mand a date and place  29d. Dele sign	ontribute to 3 Prot  24b. We every confidence of the state of the stat	o the cause of declaration of cause of declaration of cause of declaration of cause deeth?  Yes 2 No  No. I Route Number, telepath of the cause(s)

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death RAKER Yee **Physician** MALLIE APRIL, 10:17 PM 7,2000 /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL CENTER NIA If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□ F Months Days 248-36-4081 FEBRUARY 5, 1925 SOUTH CAROLINA Director Usual Residenca of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State al Hygiene. other than "natural", or thems 33e or 28e-f show went, the Medical Examiner must be notified at NIA CITY BALTIMORE 1 XYes 2 No MARYLAND Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 2604 FORESTER AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Sfefus Black, White, etc. 72 hours after 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 No by Specify: Specify: BLACK 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) LONDON FOG LABORER GRADE Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) 12 should be fill h and Mental H is merked off BAKER MAE DILIE MN-UNKNOWN MALLIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Pages 1 and 2 r Department of Health a important: if item 27 is any injury or other tra ance. CHANDDAUGHTER 4021 RIDGECROFT RD, BALTIMORE, MD 21206 YOLANDA BAKER Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremetion 3 Removal from Stele GARRISON FOREST CEMETERS O4-13-2000 WINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses 2140 N. FULTON AVENUE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Myocardial 10 DAYS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner DAYS Physician/Medical Examiner NEUMONIA ISPIRATION use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) 68760 the attending physician Due to (or as e consequenca of): Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Records, þ 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed CEREBRO YASCULAR ACCIDENT completion of cause of death? After this certificate has 2 1 No 1 Yes 2 No of Vital nepital or Attending Physician: Thours after death.

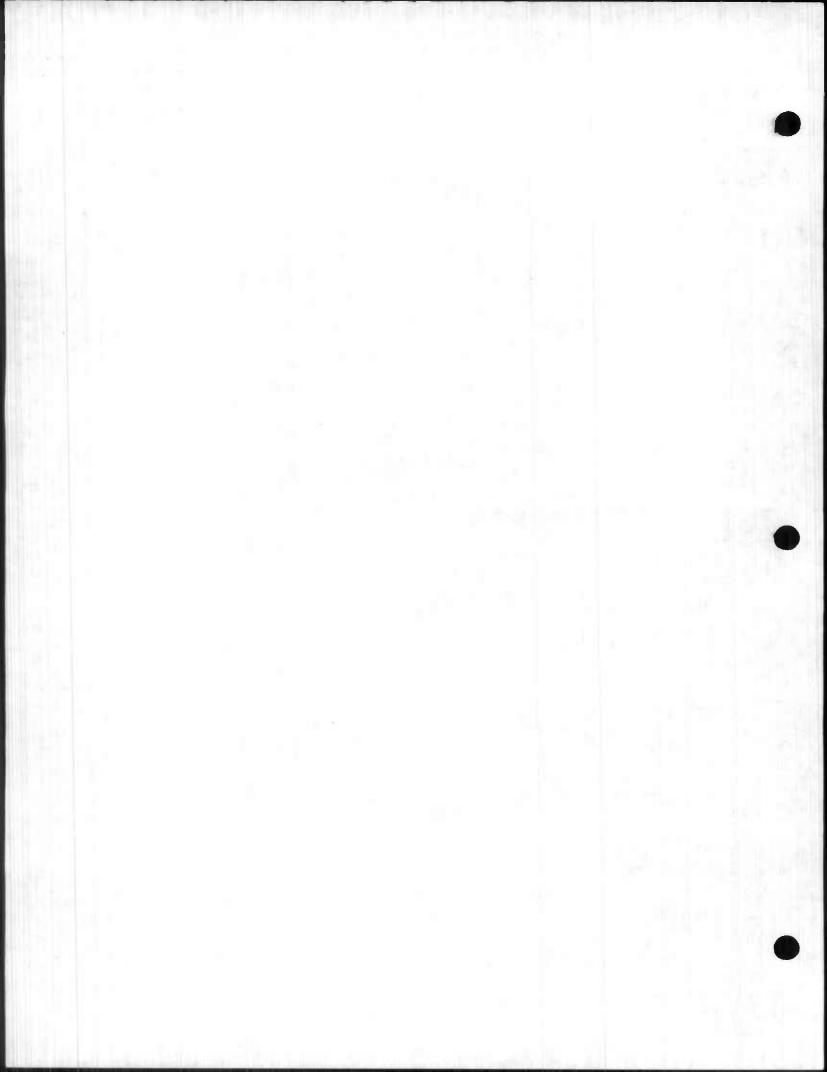
neral Director: After this certificate filled in by the funeral director, pe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient edicai Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral C Tertifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certilier 29c. License number P942 RESIDENT P13132 APRIL, 7, 2000. 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Dr. SRIKANTIN RAMAC (-I AND RUN) HARBOR HOSPITAL CENTER BALTIMORE 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Year **Physician** ducal 11:30 My 29 2000 tarch /Medical 4c. County of Death 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Hoysite 1 General Columbia If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10M 20F Hours August 29, 1927 Ohio Director 414-40-7994 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d, Inside City Limits 28a-f show must be notified 1 Yes 2 No Directo Maryland Howard West Friendship 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21794 U.S.A "natural", or flems 23st 13795 Rt.144 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) flied within 7 Hygiens. other then "n Elementery/Secondary (0-12) College (1-4or 5+) engineer 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be parmit. Pages 1 and 2 should be 1 Department of Health and Mental I reportant: if from 27 is marked of Sara Collins Oliver Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) 13795 Rt.144 West Friendship, Maryland 21794 Bobbie Mae Bell Spouse 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 Suriel 2 □ Cremation 3 □ Removel from Stete McKendree Cemetery 4 Dopation 5 Other (Specify) 04/02/2000 West Friendship, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Slack Funeral Home, P.A MENDS 25 3871 Old Columbia Pike Ellicott City, MD 21043 2011. Port 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** Immedieta Causa (Final diseese or condition resulting in death) /Medical do llespiratury Examiner Dua to (er as e consequence of) Examiner physician and the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disaase or Injury thet initiated events resulting in death) Last Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. been signed by 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has page 1 Yes 22 No 1 ☐ Yes 2 ☐ No Consucry cxiscust Division of Vital certing 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury at Work? or Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune. 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 1)46120 2000 30. Neme and address of person who completed causa of deeth (Item 23a) (Type, Print) 10724 tuxent Down big 1.44/e

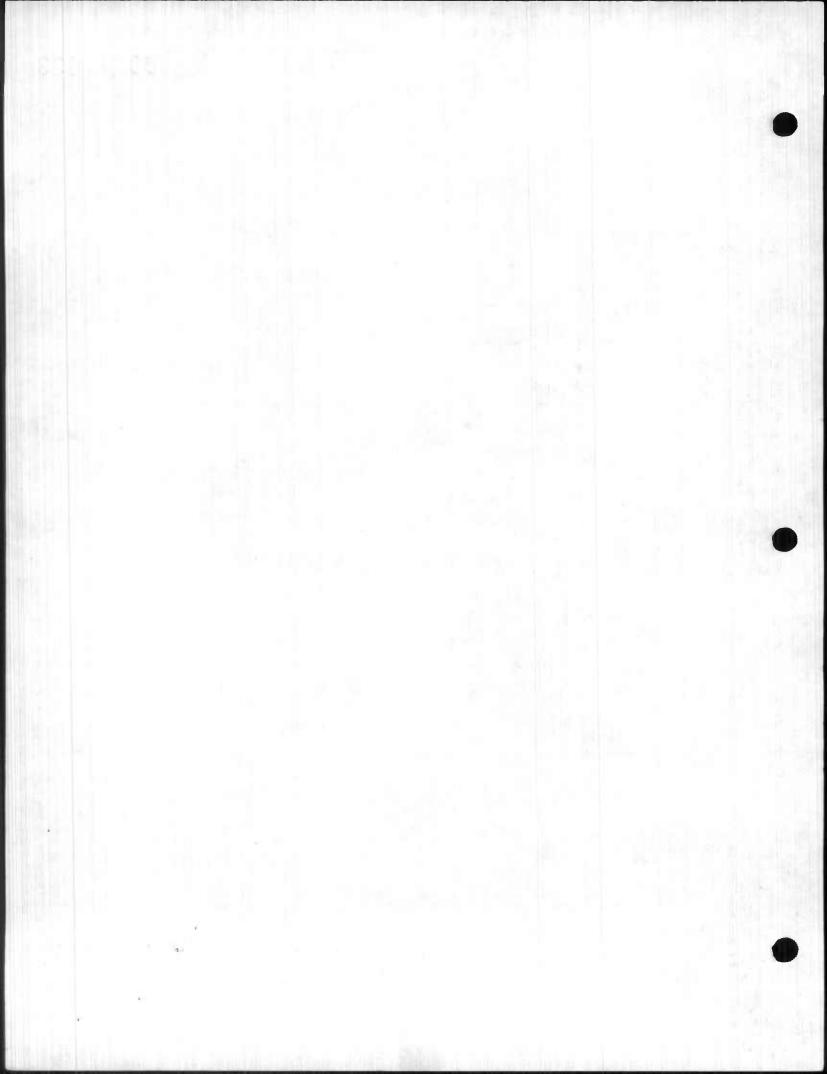
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DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

2000

32. Registrer's Signeture

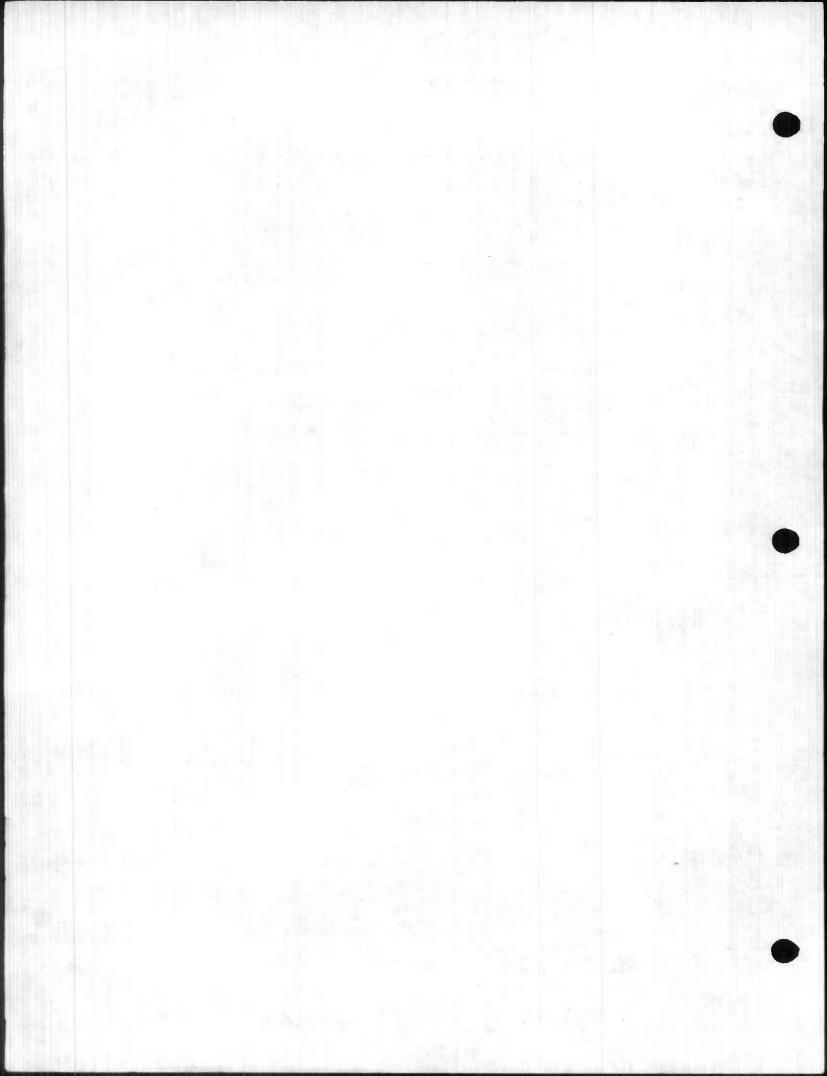


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31. Data filed (Month, Day, Year)

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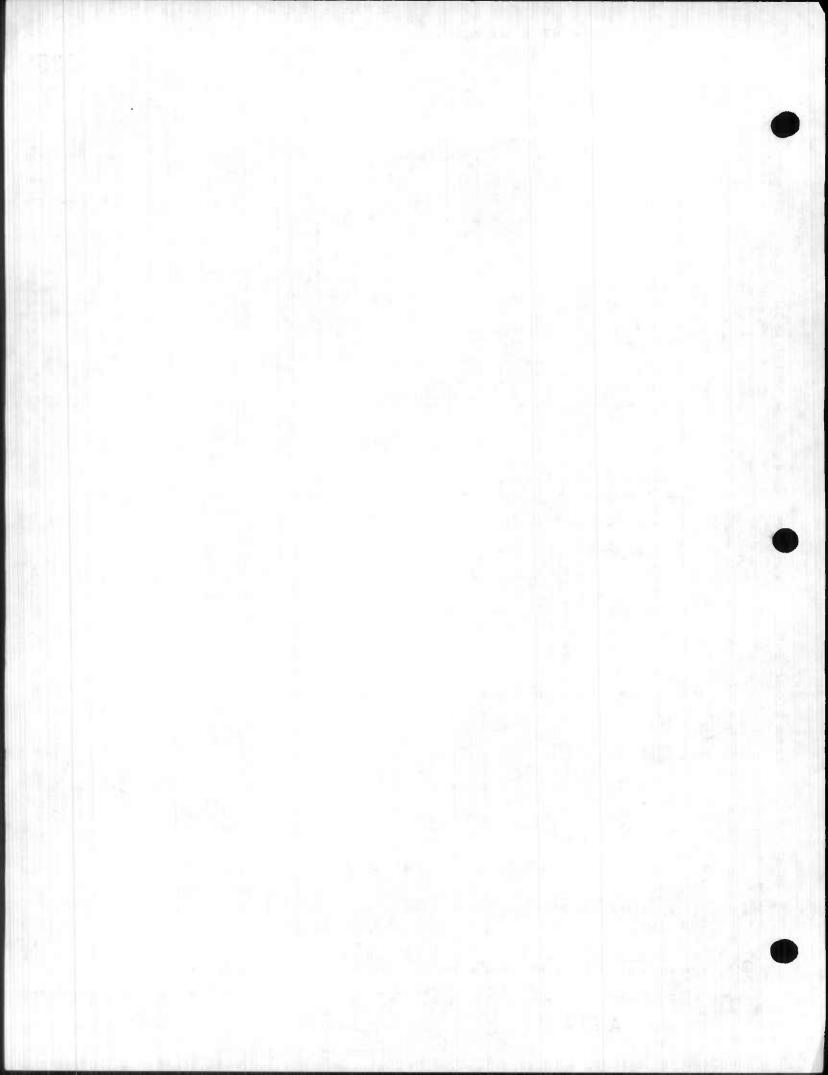
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State of Maryland / Department of Health and Mental Hygiene 00 11635

	Certificate of Dea		Reg. No.	0 0	11000	
sician	1. Decedent's Name (First, Middle, Last) GEORGE THOMAS BALDWIN, SR.		onth Pay	2000 Year	3. Time of Death 12:40 AM	
edical		ty, Town, or Location		County of Death	12.40 111	
miner		LEN BURNIE		ANNE ARUNDEL		
i	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If U			9. Birthi	olaca (State or Forei	
	218.09.4629 12M 2 F 84 Yrs. Months Days Hor	ours Min. 12	ta of Birth onth Day, Year) 725/1915	MARY	PAND	
	Usual Residence of Decedent					
	10a. State   10b. County   10c. City, Town or Location   MD   ANNE ARUNDEL   GLEN BURNIE				10d. Inside City Limit	
					1 ☐ Yes ZON	
	10e. Street and Number 10f. Zip Code		10g. Citiz	ten of What Cou	ntry?	
	11 WENDOVER ROAD 21060			USA		
	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2√3/Married  12. Was Decedent of Hispanl if Yes, specify Cuban, Me  13. Was Decedent of Hispanl if Yes, specify Cuban, Me	exican, Puerto Rican,	etc.)	<ol> <li>Race - Amaric</li> <li>Black, Whita,</li> </ol>		
	1 Never Married 2CKMarried 11∑Nes 2 No 1941 — If Yes, Give 1 No 1941 — 1 Yes 2√2No Spe 1 No 1945 → 1	ecity:		Specity: WI-	IITE	
	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kir	nd of Business/In	dustry	
	(Specify only highest grada completed)  (Giva kind of work done during life. DO NOT use retired)  Elementery/Secondary (0-12)  College (1-4or 5+)	most of working				
	8 WAREHOUSEMAN		FT	. MEADE		
	17. Fathar's Nama (First, Middle, Last) 18. N	Mother's Neme (First	, Middle, Meiden	Sumeme)		
manufacture of the	SAMUEL BALDWIN	SARAH JON	ES			
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No.				Code)	
	ANNA LOUISE BALDWIN - WIFE 11 WENDOVER ROAD	, GLEN BUI	RNIE, MD	21061	DECEMBER 1	
	20a. Method of Disposition  1 ∑∑ virial 2 ☐ Cremation 3 ☐ Removal from State  20b. Placa of Disposition (Name of camefery, crematory or other placa)	Date	e 20c. Lo	cation - City or To	own, State	
	4 □Donation 5 □Other (Specify) MARYLAND VETERAN CE			NSVILLE	, MD	
	21. Signatura of Funeral Service Lightsee   22. Name and Address of F					
	KELLY GREGORY FINK 426 CRAIN HWY	Y., SW, GL	EN BURNI	E, MD 2	1061	
	23a. Part I. Enter the disease, on complications that caused tha death. Do not anter the mode of dying, suc short, or heart fellure. List only one cause on each line.	ch as cardiac or respi	iretory arrest,	1	Approximate Intervel Between	
	1 / 0				Onset and Death	
	Immediate Couse (Final disaase or condition Acute Regionally)	foul	we		× 6 month	
	resulting in death)  a.  Due to (or as a consequenca ot):	1.			· ^ 2 \ / /	
	b. Delaferal Phelli	nonea		10	x 3 mon fl	
	Sequentially list conditions, if any, leading to immediate					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	energy		1,	x 6 went	
edicai	that initiated events resulting in death) Last Dua to (or as a consequence of):	0				
	d					
	Cont. Other design		D. D. L.			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Per I. 2	1 Yes 2		o the cause of deat	
f	- 1904 - Menter dependent frabel	l,	10 108 21	_ NO _ 3 FTO	Jacon Jacon Line	
	- Pld 00 h 3 to 00 03	1 0 2	4a. Was an autop	sy 24b. W	ere eutopsy tindings	
	Crear acreven Cilera	Cent	performed?	CC	ompletion of cause deeth?	
	- Hyrerterien		1□ Yes 2	No 1	Yes 20 No	
	25. Wes case referred to medical 26.1	Place of Death (Che	ck only one)	1		
	axaminar?	Nursing Home 5		Other (Speci	tv)	
	27. Mapnar of Death 28a. Dete of Injury 28b. Time of 28c. Injury at		escribe how Injury		,,	
	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Lo	ocation (Street and ity or Town, State)	d Number or Run	al Route Number,	
	building, etc. (appeary)		ly or rown, clare,			
	29a. Certifier (Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion,	ate and piece, and du	e to the ceuse(s)	and menner es s	stated.	
	one) and manner stated.		ne time, dete end	piace, and due t	o trie cause(s)	
	29b. Signature and title of certifier 29c. License num	nber	29d. Date	e signed (Month,	Day, Year)	
	Salvhen V- Kaminer NW 00038	8912	04	10/6	00	
	30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 1720 CV	rain Hal	hway	Printe	204	
	SALVACION D. RAMIRGZ H.D. Glan Bu	chie K	02106	1		
e	31. Data filed (Month; Day, Year) 32. Registrar's Signature	10	72100	1		

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#18 perFHG782 4/11/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOROTHY BARK APRIL 1, 2000 8:30 P.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE N/A If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 KF 212-80-0163 Director 80 DEC. 25, 1919 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5833 PARK HEIGHTS AVENUE 21215 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE ğ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Destinant of Health and Mental Hygien. Important; if Item 27 is married other tha any injury or other traumatic HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadie Rosen SAMUEL MARY **EDLAND** BESELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRIS STINE / DAUGHTER 10 JENNER COURT - OWINGS MILLS, MD 21117 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) CHERNIGOVER CEMETERY 4/3/00 ROSEDALE, MD 22. Name and Address of Facility 21, Signetura of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betw Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical M APPROVED BY SECONDAL PROMINERS MASSIVE CEREBRAL CONTUSION Due to (or es a consequence of): Examiner SUBDURAL HEMATOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): FALLING DOWN STAIRS Physician/Medical CENTRE FOR Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2N No 3 Probably 4 Unknown BLINDNESS, CHRONIC ATOXIA, DEGENERATIVE Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy ARTHRITIS 1 ☐ Yes 2 No 1 ☐ Yes 🐉 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 28b. Time of Injury 9:00 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 DNatural 5 Pending investigation РМ 1 Yes 2X No 3/31/2000 20 Accident PATIENT FELL DOWN STAIRCASE 6 Could not be determined 3 Suicide 281. Location (Street and Number on Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Examiner sician and burial-transit be axecuted physician the buria 68760 The law requires that the death certificate Box 130 P.O. Records, page 2 of Vitai Physician: this funeral Division Attending

the Maryland

72 hours after

21215-0020

Baitimore, Maryland

280-1

b

238

"natural", or

fled within 7 Hyglene. other than "n

To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completely filled in by the fun

m

State

29b. Signeture and little of continer 30. Name and address of person who cort DR. HARRY W. KAPLAN, M.D.

4 ☐ Homicide

(Check only

31. Date filed (Month, Day, Year)

29a. Certifier

eted cause of death (Item 23a) (Type, Print) 32. Registrar's Signeture

NO

29c. License number

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D40371

90 PAINTERS MILL ROAD - OWINGS MILLS, MD 21117

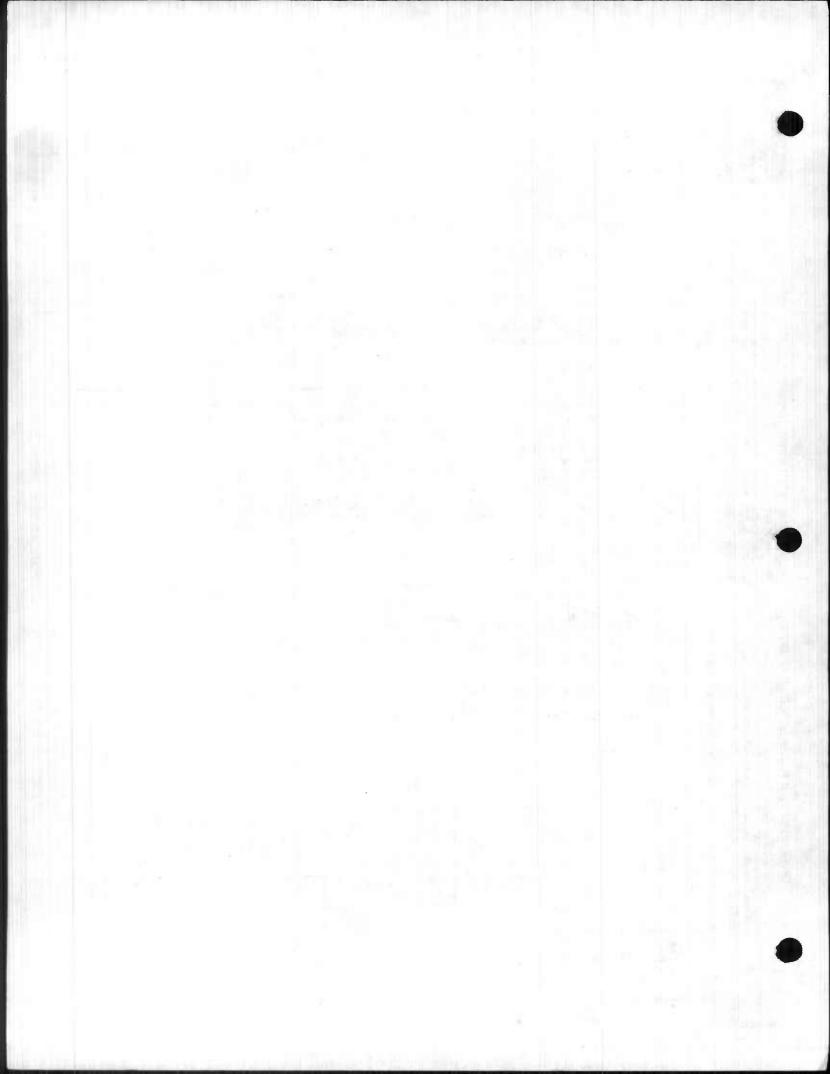
5833 PARK HEIGHTS AVE. 21215

29d. Date signed (Month, Day, Year)

APRIL 2, 2000

Registrar **DHMH 16 Rev 6/95** 

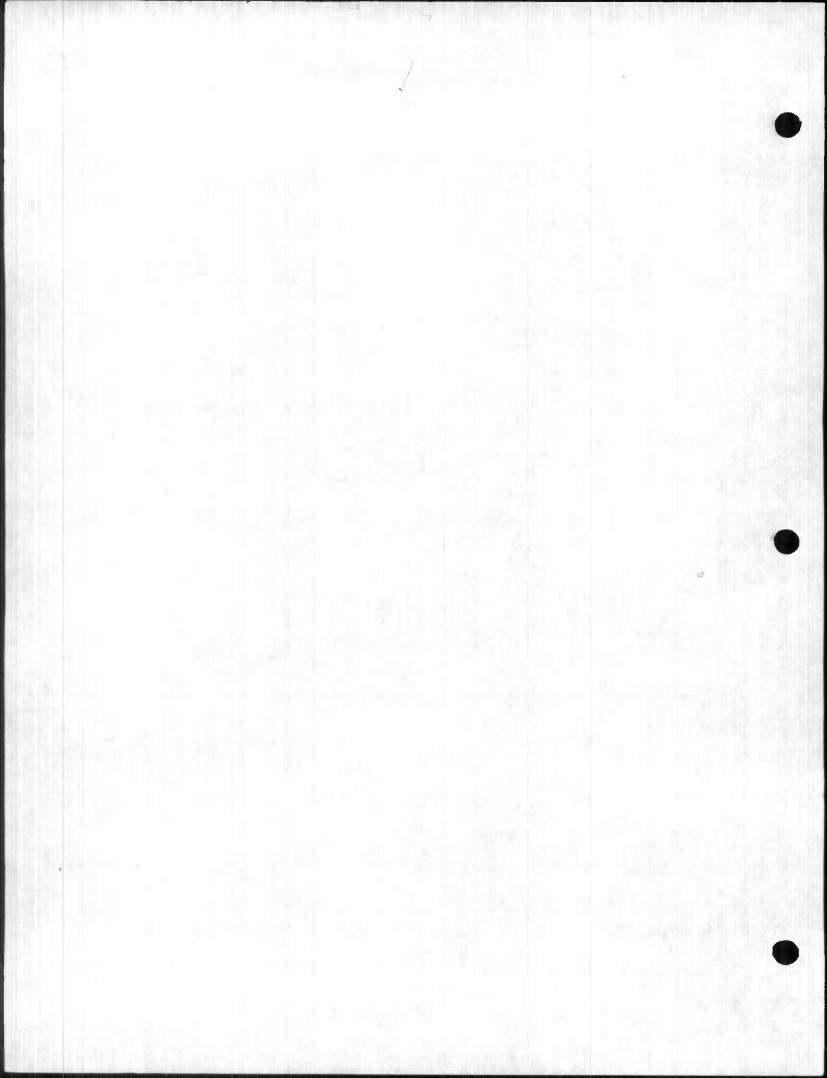
WEINBERG ASSISTED LIVING FACILITY



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 11637

Dhuaicic			Ceninca	te of Death		Reg. No.	0 1	1001
Distriction	1. Decedent's Neme (First, Middle, Li			UI-ELIM .	2. Dete of Det			3. Time of Death
Physician	Thomas	Cor	read		April	Day 9	Year 2000	16:45
/Medical Examiner	4e Fscility Name (If not institution, gir	ve street and number)	a Maria and T	4b. City, Town, or	Location of Death	4c. County	of Death	
	Johns Hook	sins Hospit	41	Baltin	iore	Balti	more	City
Funeral	5. Social Security Number 6.	Sex 7. Age (In yr.	s. last birthday) If Under	er 1 Year If Under 24 Hr	8. Dete of Birt	Vegri	9. Birthplac	e (State or Foreig
Director	211-22-6562	1½ M 2□ F 70	Yrs.	Days Hours Mir	8. Dete of Birth (Month, Det SEPT 29	, 1929	Ohio	
	Usuat Residence of Decedent	140-0					101	Lordo Gh. Linh
ms 23a or 28a-l show creat be nothled at	10e. State 10b. County		City, Town or Location				100	Inside City Limit
28a-1 aho nominal at	PA Dauphi	n H	arrisburg		1			2.1
Dir.	10e. Street and Number			p Code		10g. Citizen of W		?
23a	1404 Karen Dri			7109		US		
	11. Marital Slatus	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was Deci	edent of Hispanic Origin? ( ecify Cuben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Blac	e - American k, White, etc	
than "natural", or ha	1 Never Merried 2 Merried	1 ☑Yes 2 ☐ No If Yes, Give	1 ☐ Yes	2 No Specify:		Specify	Whi	+ 0
d Fig.	3 Widowed 4 Divorced	Year or Dates:				101 101 1 1 1		
ygiene. er than "naturn rt, tr. Hedical Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Us (Give kind of w	ual Occupation ork done during most of w use retired)	orking	T. N. T		
iene. Tra Han Omp	Elementary/Secondary (0-12)	College (1-4or 5+)					ress	
	1 () 17. Father's Name (First, Middle, Las	<i>t</i> 1	Truck I		ame (First, Middle,			
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2 - 2	19a. Informant's Name/Relationship Gloria Conrad/		_	en Drive,				
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o H	1 □ Burlel 2 □ Cremetion 3 [	Removel from Stete	cemetery, crematory or	other place)	0			
tant	4 Donation 5 Other (Speci			ciety of PA				PA.
Department of Health in Important: If item 27 is any Injury or other tra	21. Signature of Funeral Service Lige	mald mald	Crema	nd Address of Facility	y of Mary	land, I	nc.	
.0240	Dawn F. McDon	ald	299 1	Frederick Rd	. Baltimo	re, MD	21228	
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nysician		T 1						nset end Deeth
Medical xaminer	Immediate Cause (Finat disease or condition resulting in death)	Intraa	bdomina	sepsis			1	8 days
	resulting in death)	Due to	(or as a consequence of	):			ſ	
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<b>3</b> 0 0	Cause (Disease or Injury							
physici the bu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to	(or as a consequence of	:			l l	
ding physicien and se as the burial-transit	fust initiated events	Due to	(or as a consequence of					
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signed by the attending physici d be deteched for use as the bu d by Physician/Medical	resulting to death) Last	d			101	708 2 No	3 Probel	oly 4 🗆 Unkno
seen signed by the attending physicishould be detached for use as the bueted by Physician/Medical	resulting to death) Last	d			1 🗆 '	· ·	3 Probate 24b. Were evaile comp	autopsy findings
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GERALDINE D. CADDICK APRIL 1, 2000 11:45 PM 4e Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth WESTMINISTER
If Undar 1 Year If Undar 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. 0c (Month, Day 1935) WESTMINISTER NURSING & REHAB CENTER CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□ M 2♥ F Hawaii 64 Yrs. 215-30-7872 Usuel Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Westminister Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 1234 Washington Road 12. Was Decedant Evar In U.S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married Specify: White 1 Yas 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) unknown emergency service tech 18. Mother's Name (First, Middle, Malden Surname) 17. Fathar's Neme (First, Middla, Last) Ambrose E. Caddick Thelma C. Moniz 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminister Nursing & Rehab Ctr 1234 Washington Road Westminister, Md 21157
Disposition (Name of Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removei from State 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Funded Service Licensee Rohald S. Wade, 22. Name end Address of Fecility frector State Antomy Board 655 W. Baltimore Street mour Baltimore, Md 21201

23e. Part1. Enter the diseesa, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat end Deeth Immediate Cause (Finel disaase or condition resulting in deeth) Due to (or es a consequence of) sum Due to (d) es e consequence of): Sequantielly list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initieted avants Due to (or es a consequenca of): resulting in death) Last Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? complation of causa of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examinar? 28. Piece of Deeth (Check only one) Hospital: Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Deeth 28b Time of 28c. injury at Work? 1 Neturel 5 Pending 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined

Box 68760.

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

**Funeral** 

**Director** 

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mail cal Examiner must be notified at

2 should be filed within 72 hours efter death and Mental Hygiene.
Is marked other than "natural", or items 23.

Department of Health an Important if Health an any Injury or other ones.

**Physician** /Medical

Examiner

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3 □ Sulcide

29e. Certifier

4 I Homicide

(Check only one)

Maryland 21215-0020

Saitimore,

with the Meryland

Division of Vital

Attending after death To the Hospital within 24 hours a To the Funerel C Hospital

> State Registrar

ndelleton

29c. Licensa number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year)

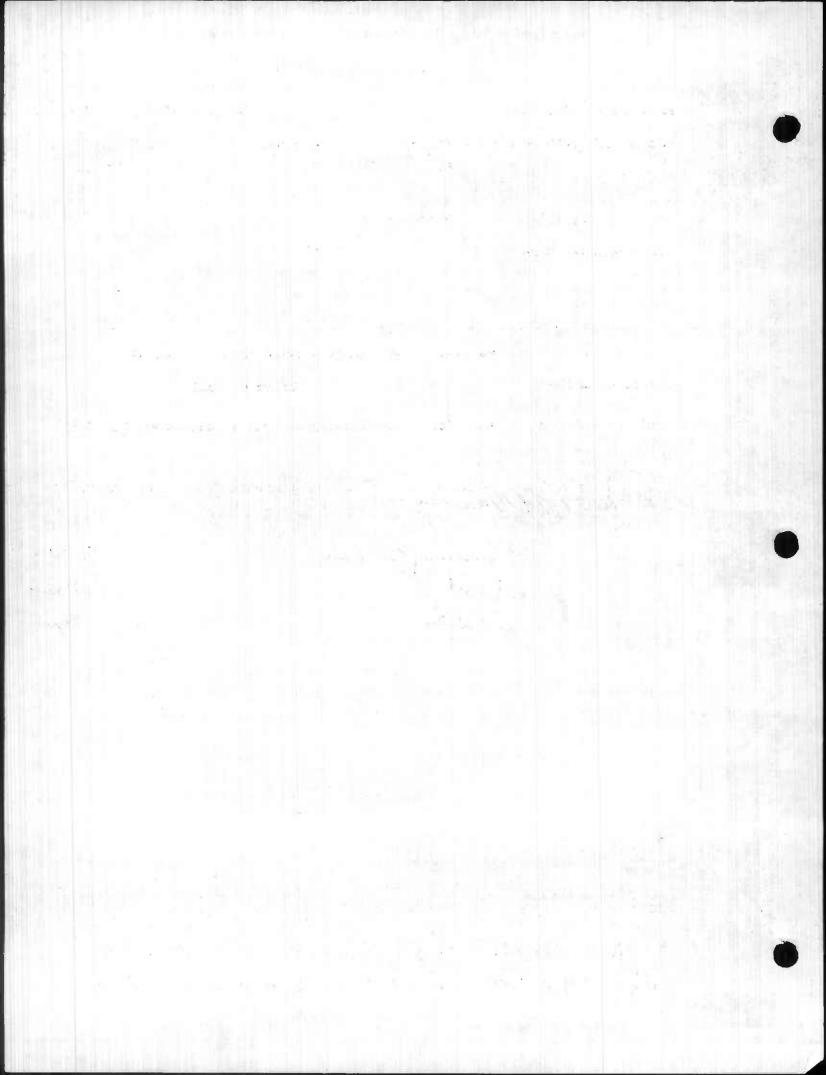
28f. Location (Street and Number or Rural Route Number, City or Town, State)

eddress of person who completed cause of deeth (item 23e) (Type, Print)

688 Poole Rd, Westminster md 21157 Middleton mo

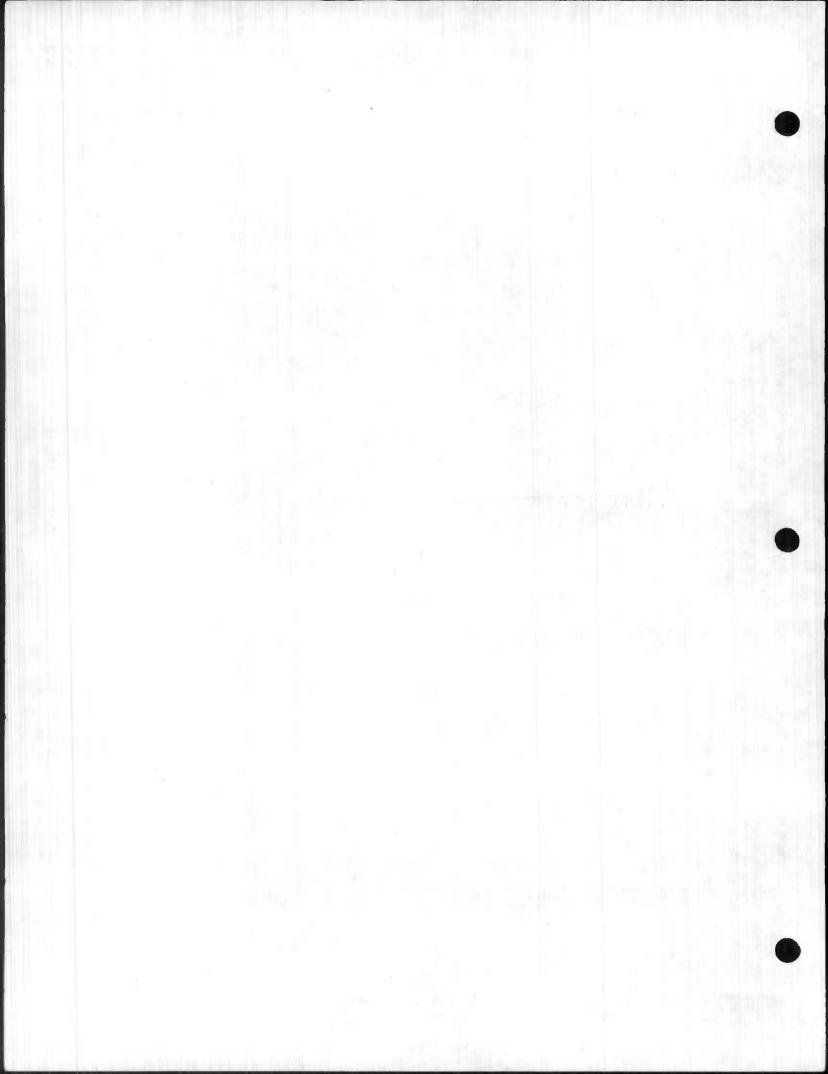
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrer's Signeture



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O.O.

HELEVINE.	And the second of the second	ma (First, Middli	e, Last)				4	2. Data of De		Mari	3. Tima of Death	
ysician Jedical	Nels	Nelson Crosby					April	. 06,	2000	10:10pm		
ner	4a Facility Name						4b. City, Town, or L		h 4c. Count	y of Death		Ī
Н	5. Social Security		Homewo		yrs. last birthday	) If Under 1 Yaar				NA 9 Bidhol		
	215-18-	-8273	1€ M 2□ F		Yrs.	Months Days	Hours Min.	12-05	19. Year) 5-16	Count	ace (Stata or Foraign try)	
	10a. Stata	10b. County		10c	. City, Town or L	ocation				10	Od. Insida City Limits	
28a-f sh notified a	MD	N.	A		Baltimo	ore		4 5			XXYas 2□No	
Il Director	10e. Street and No.	th Stre	et	10f. Zip Code 21218				10g. Citizen of Who		try?		
traminer must by Funeral	3 ☐ Widowed	mied 21 Mam	ried 1 Ye	ecedent Ever i Forces? is XIXNo Give r Detes:	in U,S. 13.	Was Decedent of If Yas, specify Cut 1□ Yas ※※No	Hispanic Origin? (Spean, Mexican, Puerto	pecify Yes or No Rican, etc.)		ce - America ack, Whita, a fy: B1		
Completed	(Spe	condary (0-12)	st grade complete College	e (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		king	16b. Kind of B				
3	8th G1		NA (act)		Lal	borer	18. Mother's Nam	a /Firet Middle			al Co.	
To Be	Solomor		ent				Annie		Crosby			
-	19a. Informant's N	Name/Relations	hip (Type, Print)	7,175	19b. Mail	ling Address (Stree	t and Number or Rui	ral Routa Numb	er, City or Town	, State, Zip	Code) 21218	
	Blanch	he E.	Daniels	5	329	E. 24tl	h Street	Balti	imore,	Mary	land	
	20a. Method of Dis		3 Removal fro	m State	cemetary, cre	osition (Name of ematory or other pla		Data	20c. Location			i
		5 Other (S		J. Olata	Voshel	l Mem.	Gardens	04-12-	-2000 I	unda	lk, MD	
be build-transit and leading a	23a. Part1. Enter shock, or he	the disease, or art failure. List	complications that	at accused the	- 1	WM.C.Mar	ch FH 1	101 E.	North	Ave	nue	
xaminer	Immediata Cause disease or conditi- resulting in death)  Sequentially list or if any, leading to it	(Finel ion	e	Cerl	death. Do not en	Uasula equence of):	ing, such as cardiac	or raspiratory a	rrest,		Approximate Interval Between Onset and Death	
d by Physician/Medical Examiner	disease or conditi- resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	conditions, mmediate lerlying triplury ts	o b c	Due to	do (or es a conse do (or as a conse do (or as a conse	Uasula oquence of):	a acee	or respiratory a	tobacco use co	ontribute to	Approximate Interval Between Onset and Death  Language  Other Cause of death?  Apply 4 Minnown	
by Physician/Medical Examiner	disease or conditi- resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	conditions, mmediate lerlying triplury ts	o b c	Due to	do (or es a conse do (or as a conse do (or as a conse	Uasula popularies of):	a acee	23b. Did	tobacco use co	ontribute to 3 Prob	Approximate Interval Between Onset and Death  Carling Transport  the cause of death?	
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Certification: To Be Completed by Physician/Medical Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated even resulting in death)  Part II. Other significations of the samminer?  1 Yes 2 2  27. Manner Dea 1 Naturat 2 Accident 3 Suicide	onditions, mmediate lerlying or injury to Last  ificant condition  If all all all all all all all all all al	b	Due to Du	to (or as a consect to (or	equence of):  eq	ven in Pert I.  26. Place of Dee her: 4 Nursing Herry at 177?	23b. Did 1 24a. Was perfect the Check only come 5 Rasis 28d. Describe 28f. Location (City or To	tobacco use co	ontribute to 3 Prob 24b. We ava con of c	Approximate Intriarval Between Onset and Death Classification of Cause of death?  The cause of death?	
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04:14 At HRISTINE HESTON 10-2000 04 4a Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death RATIMORS If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) UNIVERSITY MARILAND OF If Under 1 Yeer 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M XX 217-48-6187 76 Yrs. 03-24-1924 FRANCE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits N/A XX Yea 2 No BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 312 OVERHILL ROAD 21210 NETHERLANDS 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married Married 1 Yes XX No Specify: WHITE Specify: f Yes, Give Year or Dates: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE YEARS 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) A.W.L. TJARDA van STARKENBORGH CHRISTINE MARBURG 19a. Intormant'a Name/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ROBERT M. CHESTON (HUSBAND) 312 OVERHILL ROAD, BALTIMORE, MARYLAND, 21210 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 4-11 BALTIMORE, MD., 21202 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY Kuth 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death Immediete Cause (Final 3 MONTHS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that initieted events resulting in death) Last Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2X No t ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Piece of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed Box 68760. use as the P.O. signed by of Vital Records, page 2 should certificate has this After Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ahow

MD.

Director

Funeral

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Completed

12

r than "natural", or itema 23a or 28a-f ahor the Modical Examinar must be notified at

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Department of the Important: If the any injury or of

**Physician** /Medical

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Physician/Medical Examiner

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Medical Certification: To

3 Suicide

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To the Hospital within 24 hours a To the Funeral C Sompletely

DHMH 16 Rev 6/95

State Registrar

KACHNA GUPTA 31. Date tiled (Month, Dey, Year)

29b. Signature end title of cartifier

6 Could not be

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

32. Registrar's Signature

22 S. GREENES

Place of Injury - At home, tarm, atreet, tectory, office building, etc. (Specify)

ORIGINAL

STREET

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.

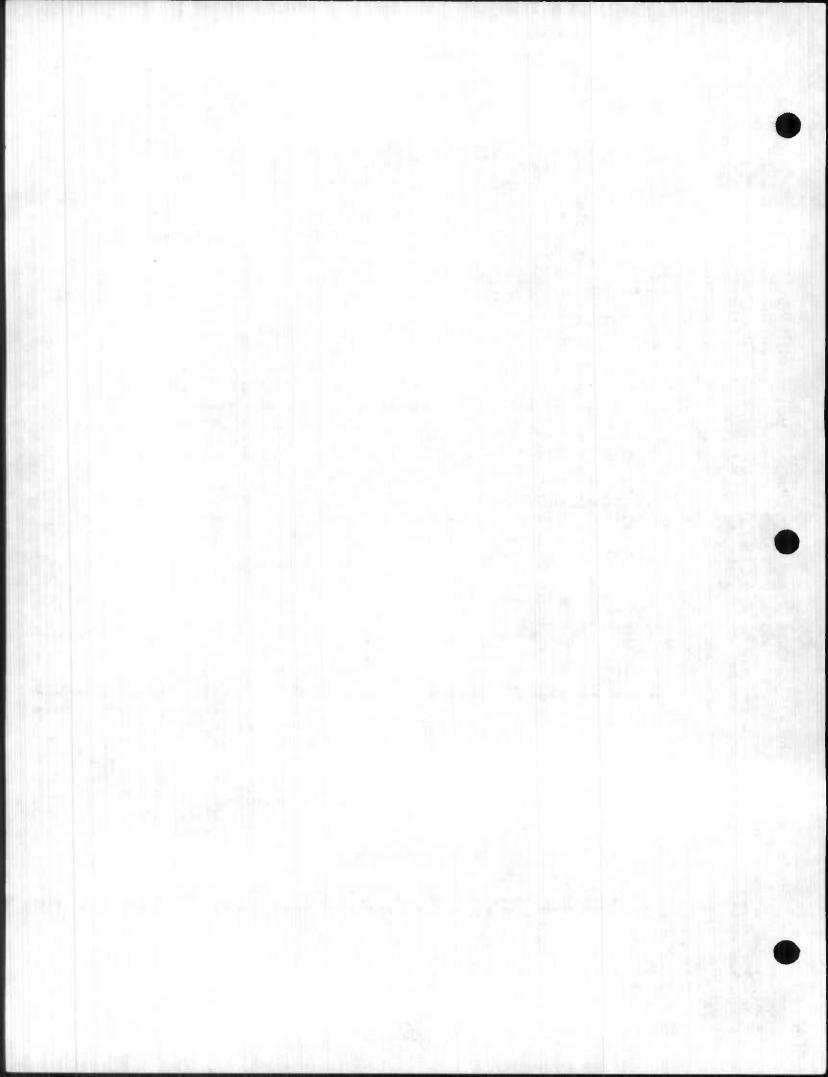
2 Medicat Examiner: On the basia of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(a) and manner stated.

29c. License number

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

107

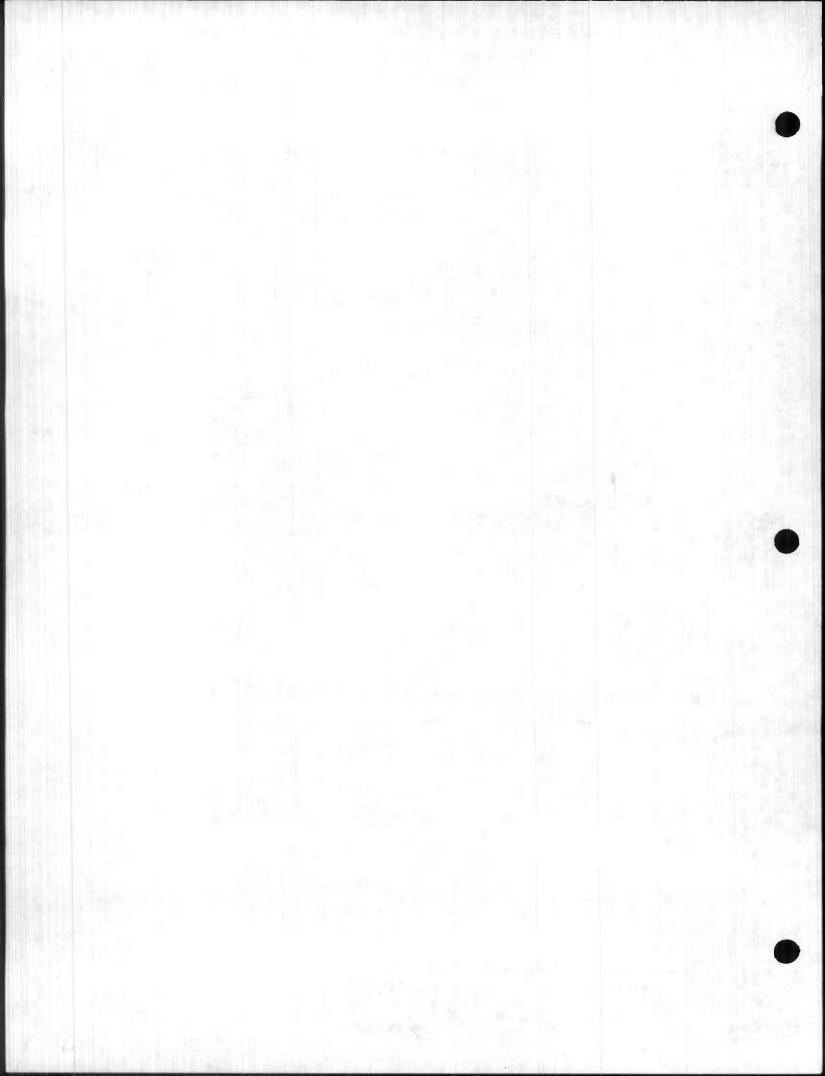


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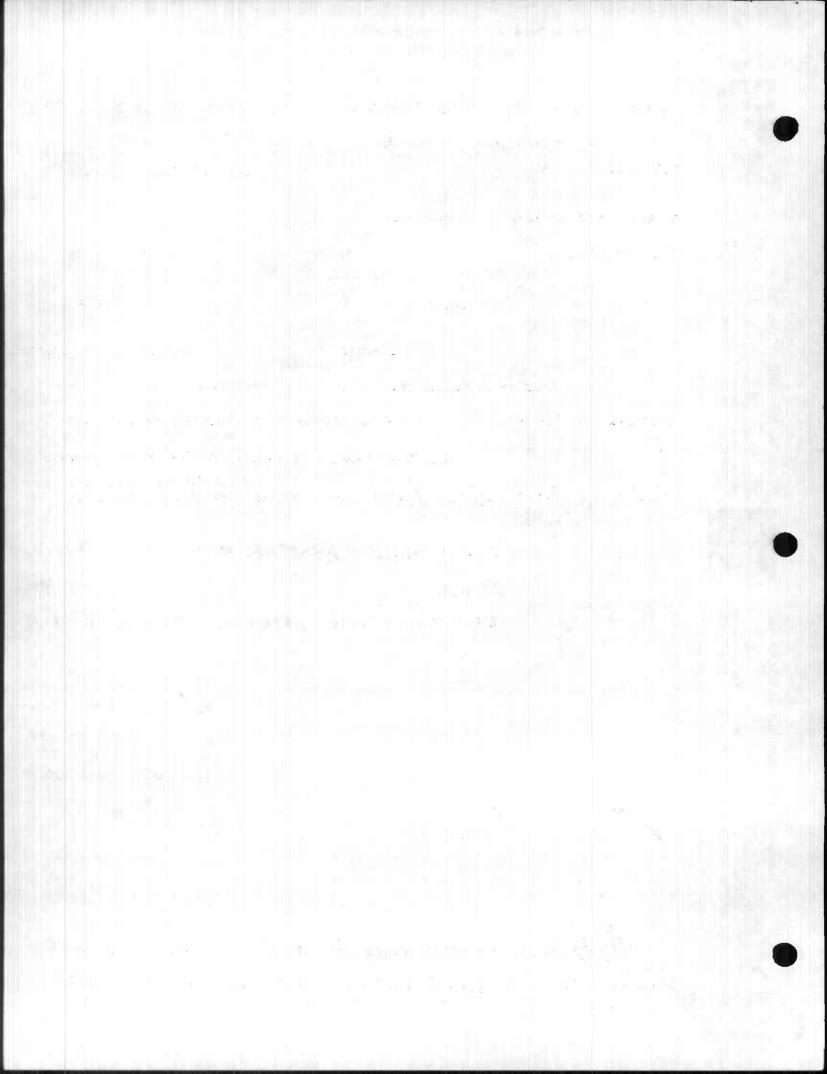
State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	F	leg. No.	11041		
Physician	1. Decedent's Name (First, Middle,					2. Dete of Dea		3. Time of Deeth		
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Examiner	4a Facility Nama (If not institution, gunton MEMOR)		BALTI		N/A					
uneral rector	5. Social Security Number 216–32–9292 Usual Rasidanca of Decedant	7. Aga (/ 1 M XXX 8 9	yrs. last birthda Yrs.	Months Days			Year) -1910	9. Birthplace (State or Foreign Country) OHIO		
NO THE	10a. State 10b. County	10	Oc. City, Town or	Location				10d. inside City Limits		
be notified at	MD. N/A		BALT		CITY		10a Citinan of Mil	XX Yas 2 No		
	10e. Street and Number 830 WEST 40	th. STREE	ET	10f. Zip Code	21211		U.S.			
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any inj ans inj	21. Signature of Funerel Service Lie	ensee		22. Name end Add HENRY W 4905 YO	. JENKI			OMPANY RYLAND, 21212		
	23e. Pert1. Enfer the diseese, or co shock, or heart failure. List or	mplications that caused the ly one cause on each line.						Approximate Intervel Between		
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fal-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	b	e to (or es e con:	sequence of):						
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is certificate has director, page 2 fo Be Comp	25. Was case referred to medicel examiner?				26. Piece of D	Deeth (Check only o	ne)			
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d in by ti	3 Suicida 6 Could no 4 Homicide determin	28e. Plece of Injury building, etc. (	281. Location (Street and Number or Rurel Route Number, City or Town, State)							
To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  10 Certifying 2 Medical Ex	Physician: To the best of maminer: On the besis of examiner and mannar states	aminetion end/or	eth occurred at the investigation, in my	time, dete and pla opinion, death oc	ice, end due to the courred at the time,	cause(s) end mer dete and plece, e	nner es steted. nd due to the cause(s)		
New	29b. Signeture end fitte of certifier	with the first states.			nse number			(Month, Day, Year)		
- 0	Chun Ha	me, mo.	Pho	AT	-2438	946 4	Amil, o	7,2000		
Ø,	30. Nama and address of person with Union Memo	1		201 E W	niv pki	wy, Ba	!timore	7,2000 MD 21218		
State Registrar	31. Date tiled (Month, Dey, Year) APR 1 1 2000	Bener	4	20.11						

TOHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** AUL 6:45PM COLIFLOWER APRIL 2000 9 EMORY /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CENTER HARBOR HOSPITAL N/A If Under 1 Yeer | If Under 24 Hrs. Birthplaca (Stete or Foreign Country) 8. Dete of Birth (Month, Day, Year, 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours M 2DF 215 10 0658 83 July 17, 1916 Maryland Director Usual Residance of Dacedant the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or frems 23a or 28a-f ahow 1 Yas 2 No Maryland Anne Arundel Baltimore Directo 10f. Zip Code 10e. Streef and Number 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is merked other than "near any highly or other traumath. 203 - 5th Avenue 21225 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indien. 11. Maritai Stefus 12. Was Decedenf Ever in U,S. Armed Forces? Bleck, White, atc ty Yes 2 No 1 ☐ Never Married 3€ Married 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorcad White Year or Dates W. W. II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) Carpenter 12th Riviera Copper & Brass 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Barbara Fleshman Charles E. Colliflower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a, Informant's Name/Relationship (Type, Print) 203 - 5th Avenue Elizabeth Colliflower / Wife Baltimore, Maryland 21225 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Glen Haven Memorial Park 4/11/00 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltime is its that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, musa on each line. Baltimore, Md. 21225 23a Part1. Enter the disease, or compleshock, or heart failure. List only of Approximate Interval Between Onsef and Deeth **Physician** Immediata Cause (Final diseese or condition rasulting in daath) /Medical 4 weeks ELECTROLYTE ABNORMAUTIES Examiner Dua to (or as a consequence of): Examiner 2 months STROKE The law requires that the death certificata be axecuted physician end s the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in daath) Lest Dua to (or as a consaquence of): DISEASE ATHEROSCLEROTIC ARTERIAL Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) SBS attending p ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ 188 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t þ been si 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed completion of cause of death? s certificate has b director, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2D No or Attending Physician: director, Be 25. Was case raferrad to medical examiner? 26. Place of Daath (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No death. 2 Accident investigation after death Director: / d in by the f 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Discomplately filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Me of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 APRIL MEDICAL ADMITTING OFFICER 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 200 S.
32 Redistrar's Signature BADE HANDVER STREET, BALTIMORE, MD SAMEER 31. Date filed (Month, Day, Year) APR 11 2000 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Vesi :35 P.M 4a Facility Nama (If not institution, giva street and number) Dr 2000 4b. City, Town, or Location of Death 4c. County of Death Sa 0 te tal 001 N/A more TOS a 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Undar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 12M 20 F Hours 82 18, 213 10 1723 1917 Dec. Maryland Usual Residence of Decedent 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits N/A 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4007 - 4th Street 21225 U.S. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 Yas 2 No If Yas, Giva 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No Specify: Specify: Yaar or Datas: WW II White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lithographer American National Can 8th 17. Fathar's Nama (First Middle Last) 18 Mother's Nama (First Middle Maiden Sumama Madeline Brower Alvin A. Cox Sr. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stefanie Doyle Daughter 108 Mallow Hill Road Baltimore, Maryland 21229 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 X Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4/7/00 Baltimore National Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee 22 Nama and Address of Facility Gonce Funeral Home P.A. mamusuln 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated evants resulting in death) Last Dua to (or as a consequence of) 010 191 Dua to (or as a conse Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 ☐ Unknown 0 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No CON 6 1 Yas 25. Was case referred to medical axaminar? 130 Yas 2□ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2/ ER/Outpatient 3 DOA 27. Mannar of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide

The law requires that the death certificate be asscuted P.O. Box 68760. physis the Division of Vital Records, been signe should be d or Attending Physician: After this after death.

2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai", or items 23a or 28a-f show Examiner must be notified at

"natural", or

Director

Funeral

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Completed

Be

the Maryland

filed within 72 hours effer

Pages 1 and 2 should be filed within ment of Health end Mentel Hygiene.

Department of Health end Important: If Item 27 is m any injury or other traumones.

**Physician** /Medical

Examiner

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Physician/Medical

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Medical Certification: To

29a. Certifiar

(Check only one)

29b. Signatura and Italia of certifian

30. Nama and addrass of person

filled in by

24 hours Hospital

Baltimore, Maryland 21215-0020

completely within 2 To the 0

State Registrar

J-e 31. Data filed (Month, Day, Year)
APR 1 1 2000

ath (Item 23a) (Type, Print) no complated 0 \$2. Registrar's Signature

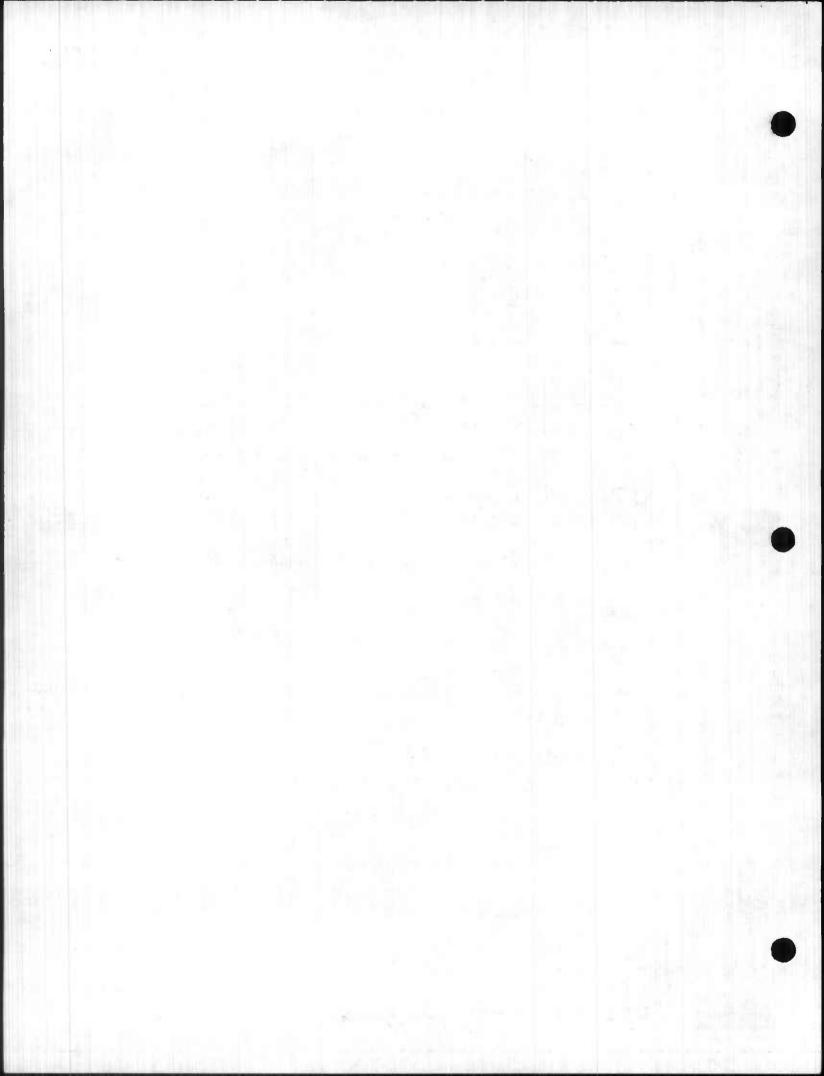
29c. License numbe

29d. Data signed (Month, Day, Year)

3001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month HOWARD LEE CRESWELL, SR. APRIL 6, 2000 7:33 PM 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth Month, Day, Year) 1/18/1944 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Deys Months Hours XXM 2DF MARYLAND Yrs. 56 216.42.5779 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 200No MD ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 299 BERKELY DRIVE 21146 USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 → Yes 2 □ No If Yes, Give 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Bleck, Whita, etc. 1 ☐ Never Merried Z Merried WHITE 1 Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PROJECT ENGINEER BUSINESS PLUS CORP. 12 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) NORMAN L. CRESWELL DOROTHY E. YOCKEL 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) MARY E. CRESWELL - WIFE 299 BERKELY DRIVE, SEVERNA PARK, MD 21146 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Burlel XXCremetion 3 ☐ Removel from State 4 □ Donation 5 Other METRO CREMATORY 4/10 BALTIMORE, MD ture of Funera 22. Name end Addrass of Fecility FINK FUNERAL HOME, PA 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061 o not enter the mode of dylng, such as cardiac or respiratory errest, Approximate Interval Batween Onset and Death and the diseesa, or complications that shock, or heart failure. List only one ceuse on each li mediate Cause (Final eese or condition fulting in death) Sequentially list conditions, if eny, leading to Immadiate ceuse. Enter Undarlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or as a consequance of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 📆 Unknown 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 1 Yes XXX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient XXI ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Death 28c. Injury et Work? 28b. Time of 1 Maturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

that the death certificate be executed P.O. Records. The law requires of Vitai or Attending Physician: Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Funeral

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Completed

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Hygiene.

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**Physician** /Medical

Examiner

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after death

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Physician/Medical Examiner

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29a, Certifier

(Check only one)

29b. Signature and title of

30. Neme and address of p

21215-0020

Baitimore, Maryland

edical Certification: Hospital 24 hours npletely To the Complete To the

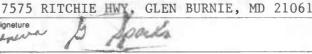
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State Registrar

M.D. 31. Data filad (Month, Dey, Year) Registrer's Signeture

eted ceuse of death (Item 23a) (Type, Print)

Eartify

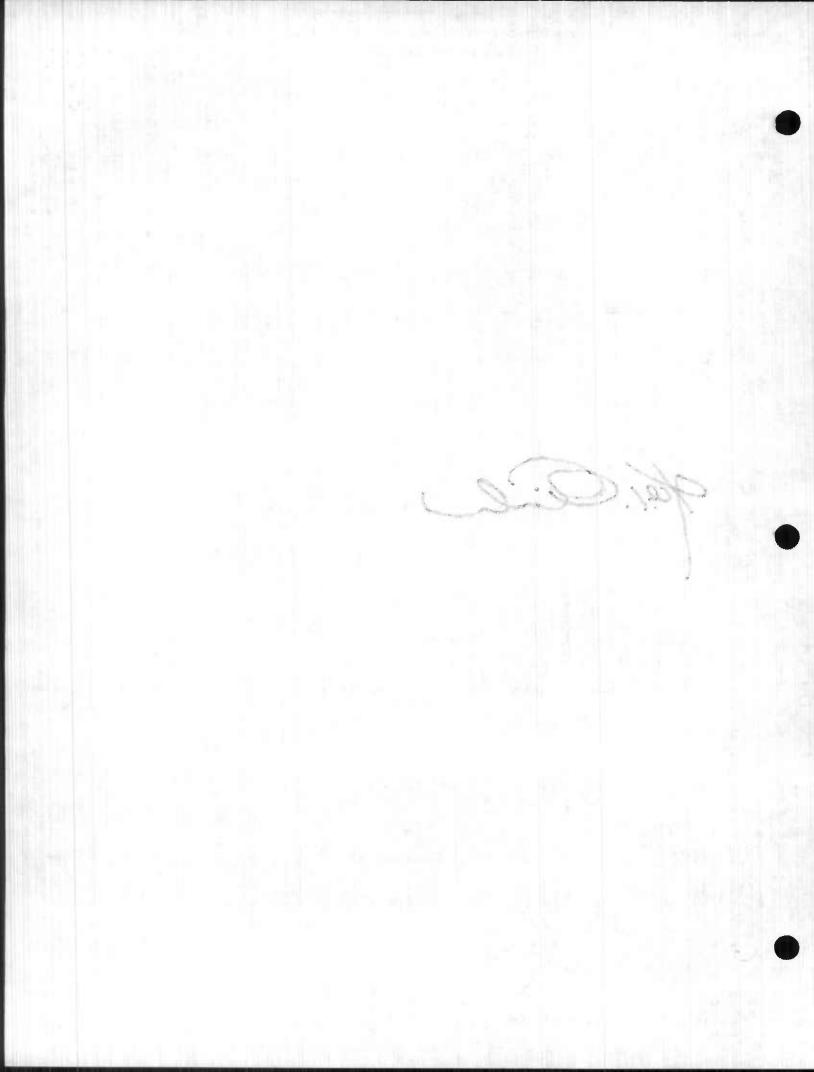


29c. Licansa number

tien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

TO the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Data signed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Bernice E. Langford-Dummett April 8, 2000 9:10 am 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgamery If Under 24 Hrs. Hours | Min. 5. Social Security Number 127–46–7873 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) July 26, 1934 9. Birthplace (State or Foreign Months Days 1 M 200 South America Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Silver Spring Montgamery ¥X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3726 Ferrara Drive 20906 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried & Merried 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurses Aid 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumeme) Walter Langford Mureil Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Neme/Reletionship (Type, Print) Clifton Dummett / Husband 601 Euclid Avenue, Brooklyn NY 11208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Saint Charles Cemetery April 13, 2000 Farminodale, NY 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervel Between Onset and Deeth Breast Cancer Immediate Cause (Final week diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

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items 23s or

permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mentel Hygiene. Important: If Nem 27 is marked other than "natural", or item any Injury or other traumatic avent, the Health and Page.

altimore, Maryland 21215-0020

traumatic avent, the Medical Examiner must be notified at

deeth with the Maryland

The law requires that the death certificate be asscuted burial-transit and attending physician for use as the burla P.O. Box 68760. been signed by the should be detached page 2 certificate Division of Vital this

Examiner Hospital or Attending Physician: funeral director, After within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

Physician/Medical Records.

þ Completed Be Certification: To

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To the

State Registrar

Medical

any

5 Pending investigation

6 Could not be

29c. License number

28c. Injury at Work?

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

D 33224

1 Yes 2 No

APRIL 06,2000

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

SOW Edmonston Dr. Rockville MD 2082 TREHAN

31. Date filed (Month, Dey, Year)

29b. Signeture end title of certifier

1 Yes 2 LN6

27. Menner of Deeth

1 DNatural

2 Accident

3 ☐ Suicide

29e. Certifler

4 Homicide

APR 11



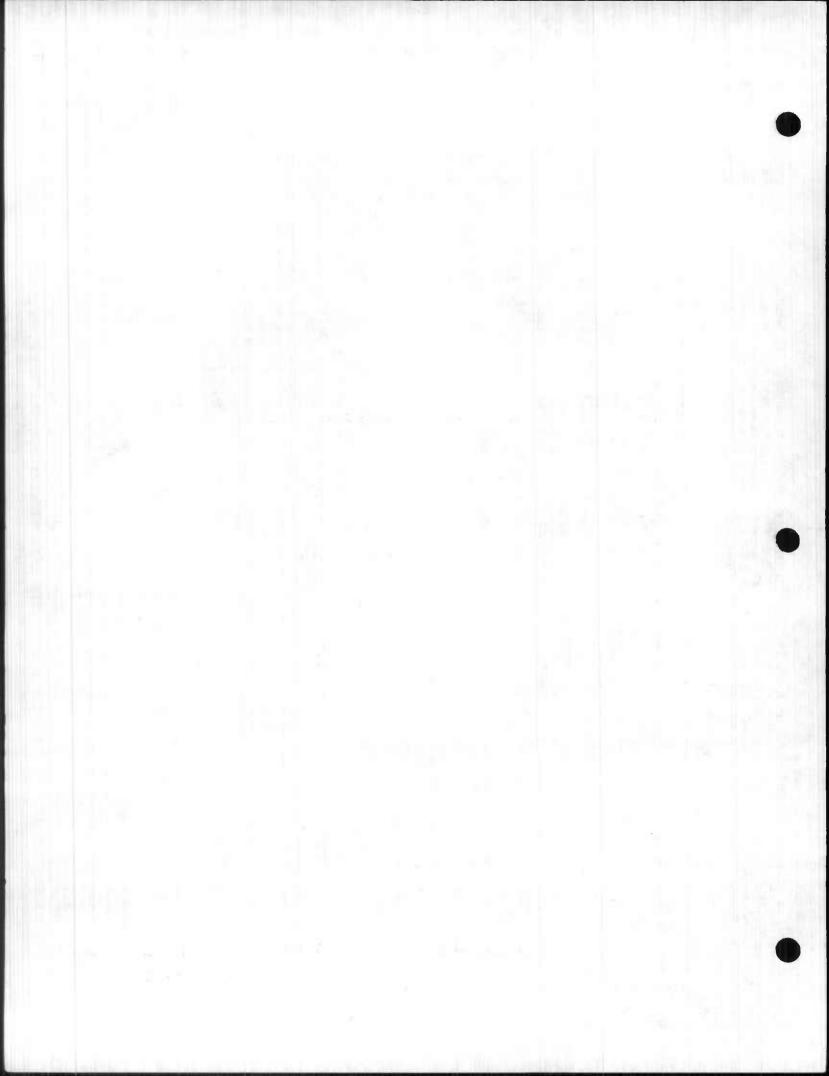
28a. Date of Injury (Month, Day Year)

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1 (Departient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 646 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:30pm FLOYD E DOTSON JR APRIL 6 2000 /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva street and number) 4c. County of Death Examiner 1305 Shore Road Wilson Point
If Undar 24 Hra. 8. Date of Birth
Hours Min. (Month, Day, Year) Baltimore If Under 1 Year 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Months Days 1X M 2 T F 68 Yrs **Director** Dec 14 1931 216-28-6064 Tenn Usual Residence of Decedent with the Manyland r 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yas 2 No Director Wilson Point 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 8 1305 Shore Road 21220 Herns 23a USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datea: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be flied within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Housel Example page. Black, Whita, atc. 1 Nevar Married 20 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: py White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Buainess/Induatry Elementery/Secondary (0-12) College (1-4or 5+) Machine Setter 12th Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd E. Dotson Sr. Elizabeth Steward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Dotson / wife 1305 Shore Road Baltimore MD 21220 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 4/10/2000 Baltimore Md. 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Connelly Funeral Home of Essex Omn 300 Mace Ave, Baltimore Md. 23a. Part1. Enter the disease, or complications that caused the death portiot enter the mode of dying, such ea cardiec or respiratory arrest shock, or heart failure. List only are cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 68760 Physician/Medical Dua to (or as a consequence of the Box ( P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Àq 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? eged 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death

1 Natural

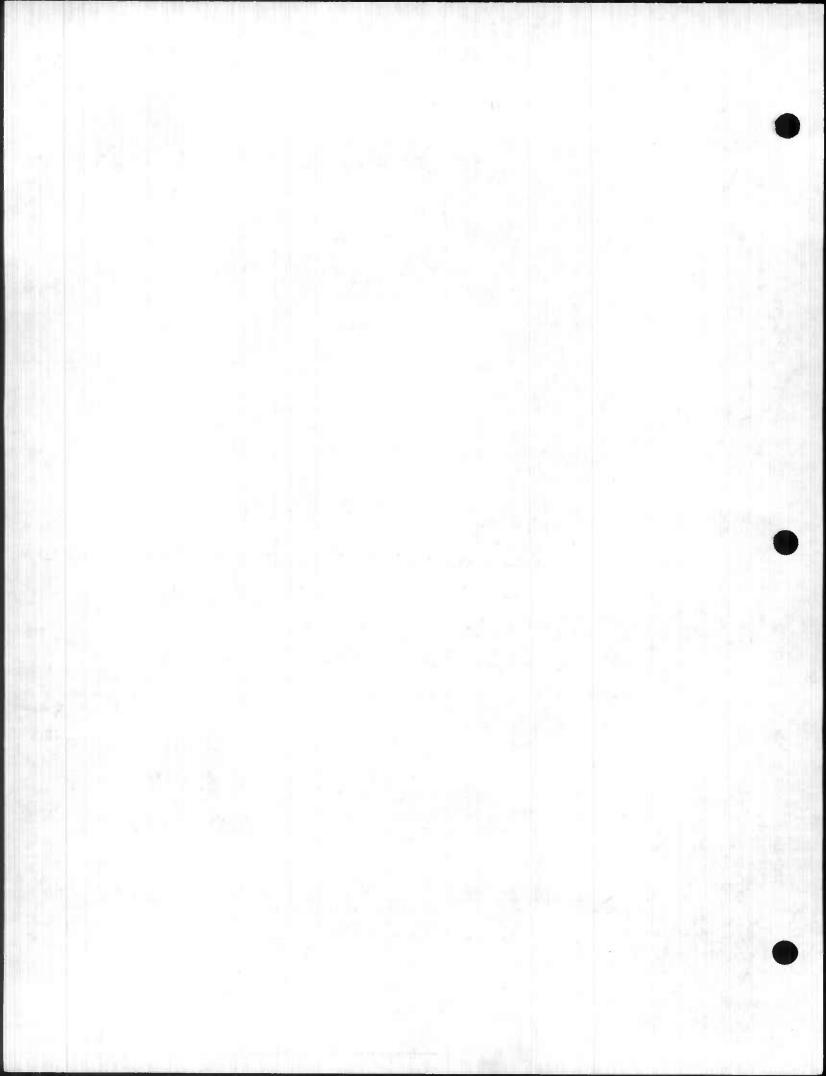
2 Accident 28a. Dete of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28d. Describa how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 Suicide 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Sing Wirza mo 30. Name and address of person who completed cause of death (Item 23a), Type, Print)

Zraz M. Za., Broch C. Dutter 31. Date filed (Month, Day, Year, 32. Registrar's Signature State oaks

Registrar

9HMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** APRIL 4, DLIN 2000 7:05 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE - GILCHRIST CENTER TOWSON BALTIMORE 7. Age (In yrs. last birthdey) If Under 6. Sex er If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foraign Country) **Funeral** 1□M 2XIF Hours 068-34-5044 Director 56 AUG. 4, Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 🗓 No Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 SUNDAY COURT 21136 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indian. 11 Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 8 21215-0020 1 ☐ Yas 2 ☑ No Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) NURSE MEDICINE Baltimore, Maryland 17, Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be sent of Health and Mental CHARLES HELTZER BURKHOFF FRANCES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 SUNDAY COURT - REISTERSTOWN, MD 21136 JOEL DLIN / HUSBAND 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₽ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 □ Othar (Specify) BALTIMORE HEBREW CEMETERY 4/7/00 REISTERSTOWN, MD 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 21. Signeture of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ehock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel monsha diseese or condition rasulting in deeth) Examiner Lei SA ZO The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical the Due to (or es e consequence of): USB BS Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ð 24a. Was an autopsy performed? 24b. Wera autopsy findings evailable prior to completion of cause of death? Completed 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medicel Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ROther (Specify) Hospice Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this funeral 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1 Neturel 5 Pending 1 Yes 2 No death. investigetion after death Director: 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medical 29e. Certifier tte Certifying Phyaiclan: To tha best of my knowledge, daath occurred at the time, date end place, end due to tha cause(s) and menner es stated. (Check only one) 2 Madical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, data end place, and due to the cause(s) end menner steted. 29b. Signeture and title of certified 29d. Date signed (Month, Day, Year) uno

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State Registrar

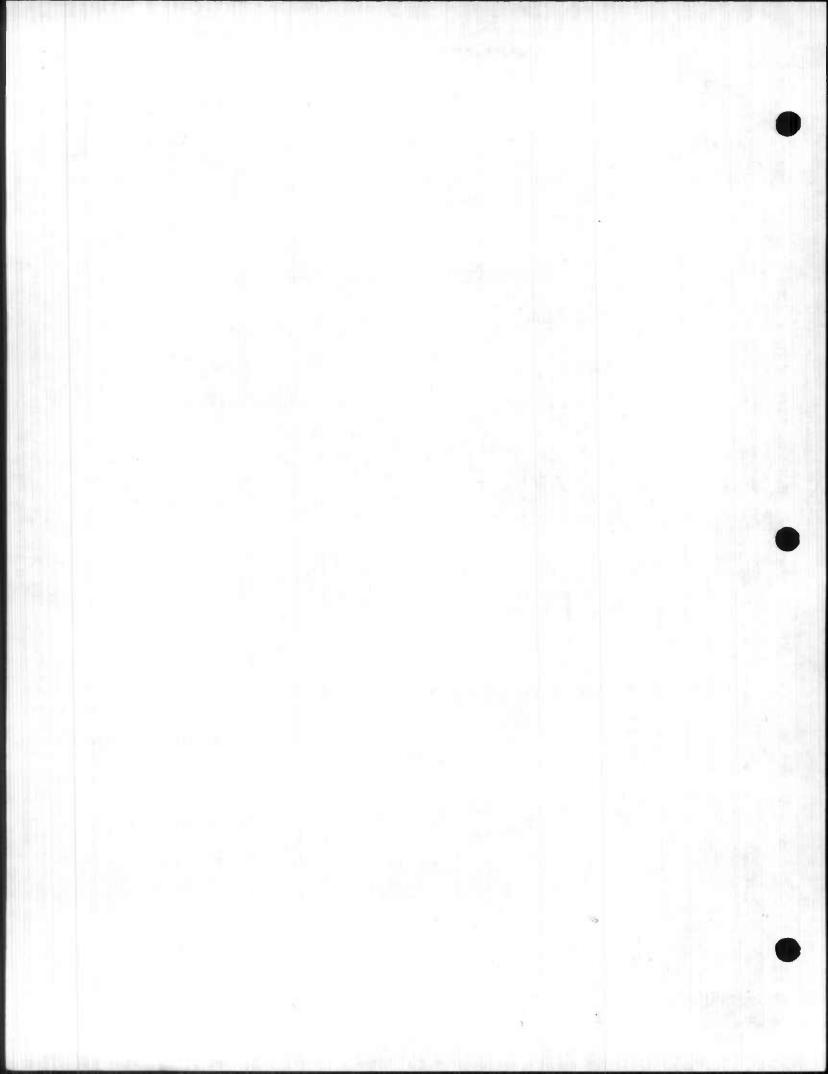
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32. Registrer's Signature

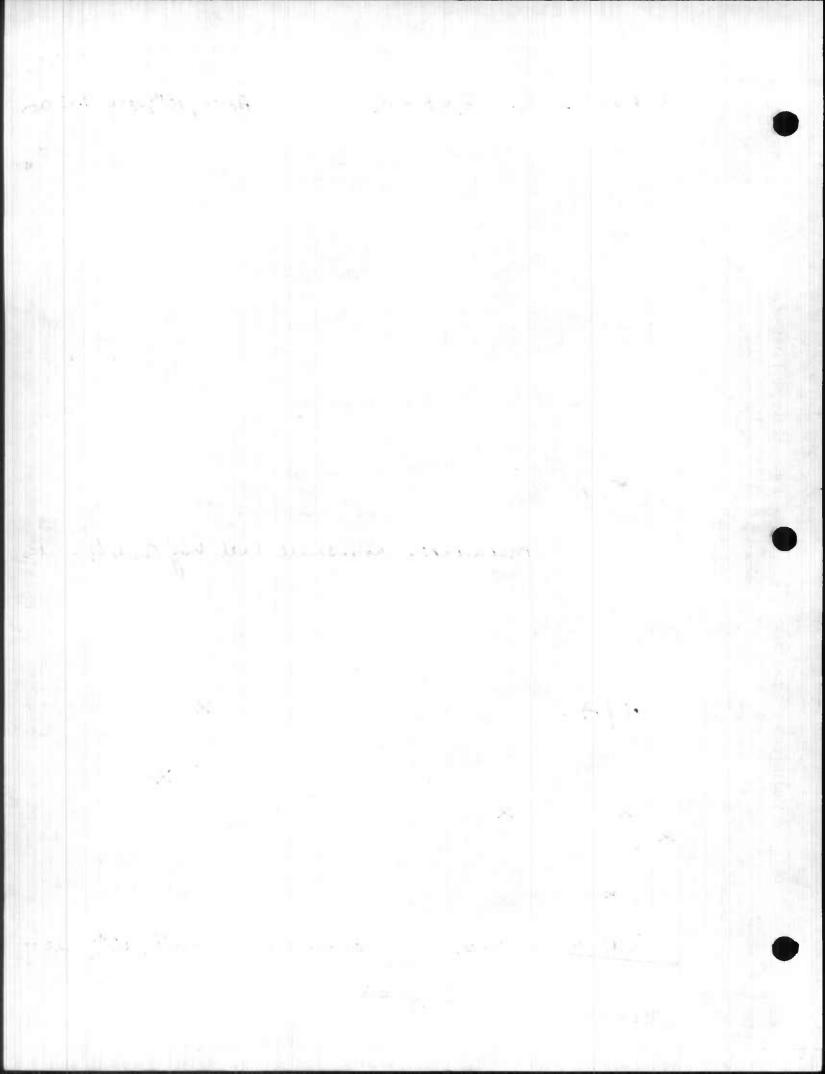


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 10th 2000 April 9.15 as **Physician** ar les ECKER /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Columbia Howard County General Hospital Howard If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10M 20F Yrs Director 66 October 7, 1933 215-30-6665 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 6001 Oakland Mills Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Ves 2 No 1953 -1 Never Married 2 Merried b 21215-0020 1 Yes 2 No Specify: Specify à 3 □ Widowed 4 □ Divorced 1958 White Year or Detes. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Distillery Elementery/Secondery (0-12) College (1-4or 5+) Palletizing Operator Unk Unk Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 Pages 1 and 2 should be nent of Health and Mental Samuel Edward Ecker Helen Dorsey 19a, Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health of Important: If Item 27 Is any injury or other tra 6001 Oakland Mills Road Columbia, Maryland 21045 Brother Mr. Samuel P. Ecker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State **Christ Episcopal Cemetery** 4 ☐ Comption 5 ☐ Other (Specify) Columbia, Maryland 04/14/2000 21. Signature of Funeral/Service Licensee. 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1400531 complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete Interval Between Onset end Death **Physician** metasteric non-smell cell ling Conce /Medical mediete Cause (Final iseese or condition resulting in deeth) Examiner Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. à 8 8 24b. Were autopsy findings aveilable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 2 X No 1 Yes 2 No Division of Vitai or Attending Physician: Be 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Daath 28d, Describe how injury occurred 28h Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Neturei 5 Pending s after death. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ( , m 141139 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Two Knolls North Drive Columbia, MD 21045 32 Pagistrar's Schalure 5000 31. Dete filed (Month, Dey, Year) State APR 11 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Anthony F. Ehart April 8 2000 12:15 am 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis Elder Care Severna Park 5. Social Security Number If Under 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Hours 1⊠M 2□ F 216 01 8953 87 Yrs. June 7, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7522 Rock Creek Way 21122 U.S. 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forces? 1 ∰ Yas 2 □ No If Yes, Give Year or Dates: W • W • II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 Navar Married 2 Married 1 ☐ Yes 2 XNo Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Accountant 12th 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Weigand Charles Ehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Mueller / Grandson 125 W. 96th Street Apt. 2K New York, N.Y. 10025 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4/11/00 Holy Cross Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvai Between Onsat and Death Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to Immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events taphylococcus that initiated events resulting in death) Last methicillin-resistant Part Ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown sungically 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Dimmune hemolytic man as there a 1 ☐ Yes 2 DNo 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

20

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter death with Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "naturali, or items 23e or any injury or other traumatic event, the Medical Experiment mantles in

Baltimore, Maryland 21215-0020

the Maryland

buriel-trensit pue physician s the buriel Box 68760. P.O. Records, funeral After

Examiner Physician/Medical p Completed Division of Vital or Attending Physician: 2 Certification: death. To the Hospital or Attend within 24 hours effer death To the Funeral Director:

State Registrar

Medical

2 Accident

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

30. Name and address of

29b. Signatura and title of certifier

investigation

6 ☐ Could not be determined

29c. Licensa number person who completed cause of death (Item 23a) (Type, Print)

1D Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

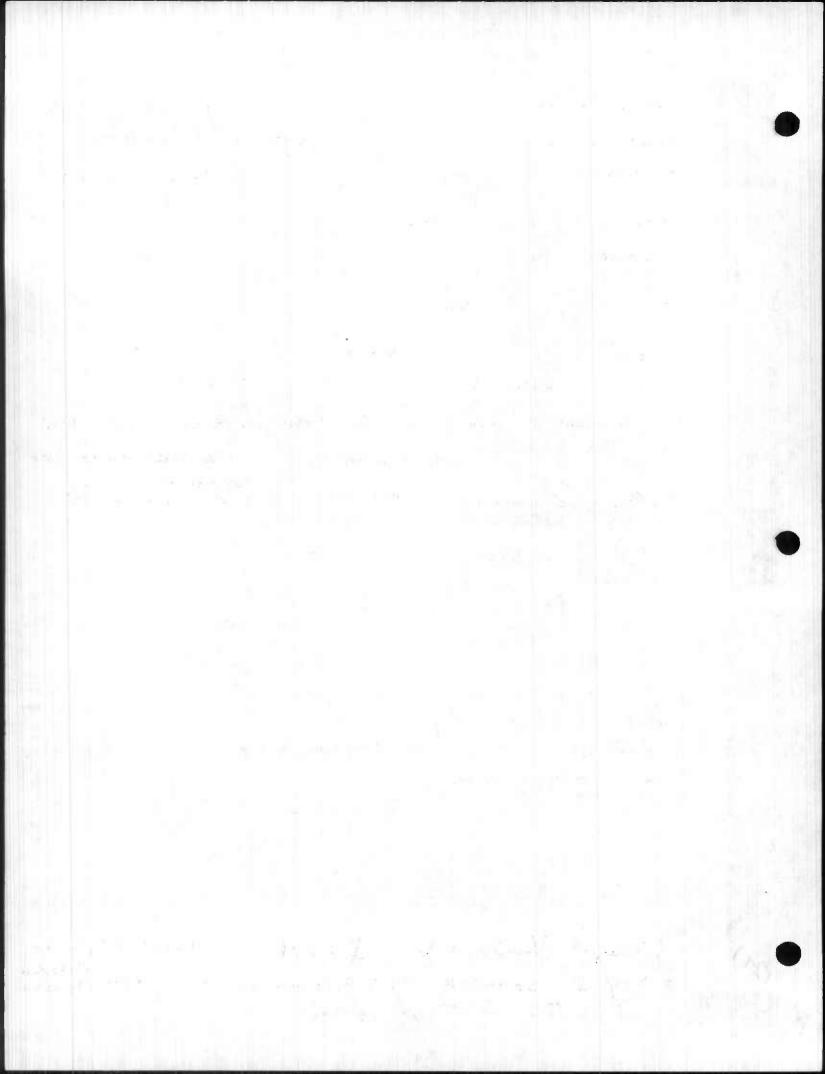
APRIL 08,2000

8418 KARBEK

Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify)

Baltimore-Annapolis

31. Data filed (Month, Day, Year) 32. Redistrar's Signature 2000 Zener



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** Ronald H. Fair 9, 2000 April 12:55 PM /Medical 48 Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Home for Hospice Towson 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. Birthplace (Stata or Foraign Country) 8. Data of Birth (Month, Dev. Year) **Funeral** Days 120M 2□ F Hours Months 215-66-0752 Director 45 April 24,1954 Maryland Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Was 2 No Director 28a-f Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b g 3036 Keswick Road 21211 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yaa or Nott Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, Whita, atc. 1 ☐ Yaa 2次次io If Yes, Giva Year or Datas: 1 Never Married 2CXMarried 8 Baltimore, Maryland 21215-0020 1 Yas XX No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Corian Fabricator Counter Collective 9 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Vernon L. Fair Shirley E. Bopst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) nt of Health a : If Item 27 is Wife Deborah Fair 3036 Keswick Road Balitmore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata Data Burial 2 Cremetion 3 Removal from Stata 4/14/00 Woodlawn Cemetery Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signatum of funeral Sarvice Ligensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximata Intarval Batween **Physician** /Medical Immediata Causa (Finat CANCEV NA diseasa or condition resulting in death) months Examiner The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Dua to (or as a consequance of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? of Vital Records, P.O. signed by t 12 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificata 1 Yes 2 No 1 ☐ Yas 2 ☐ No Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work? After Division 5 Pending 1)ENaturat death. 1 ☐ Yas 2 ☐ No 2 ☐ Accident investigation efter death 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 6 To the Hospital o within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signatura end titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 6BMC le St. Balto. Md 2,20% 6701 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

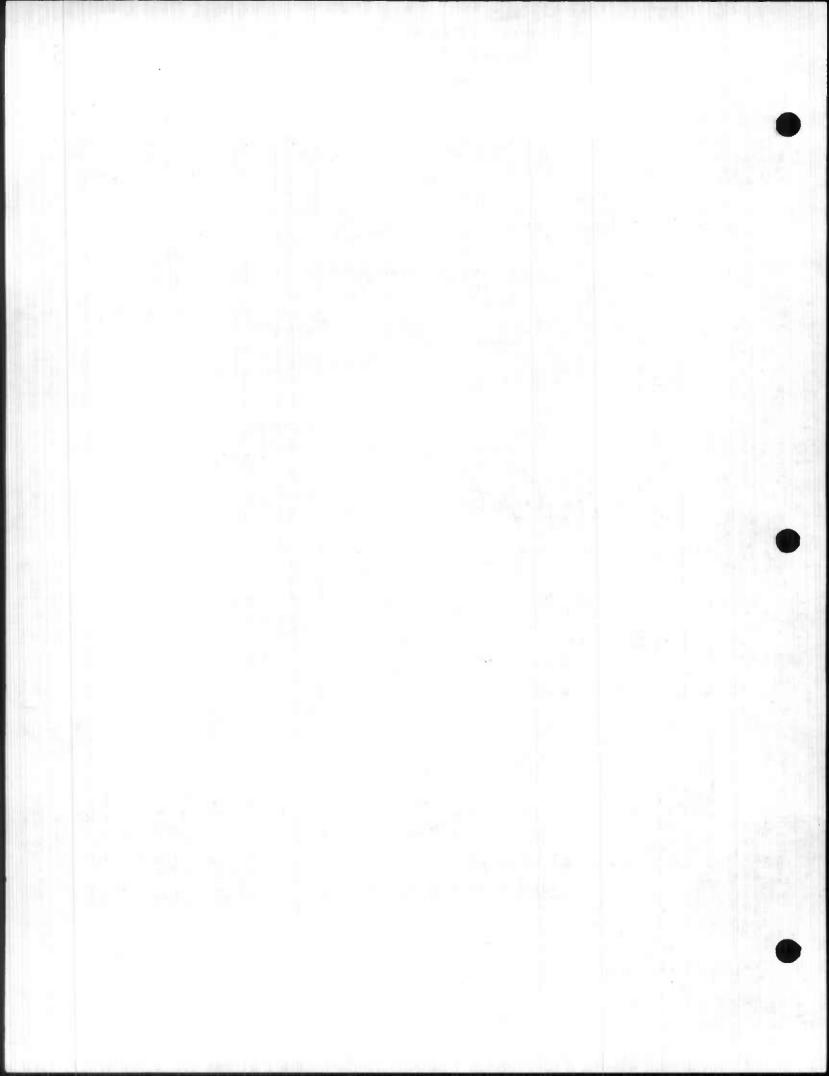
**DHMH 16 Rev 6/95** 

State

Registrar

2000

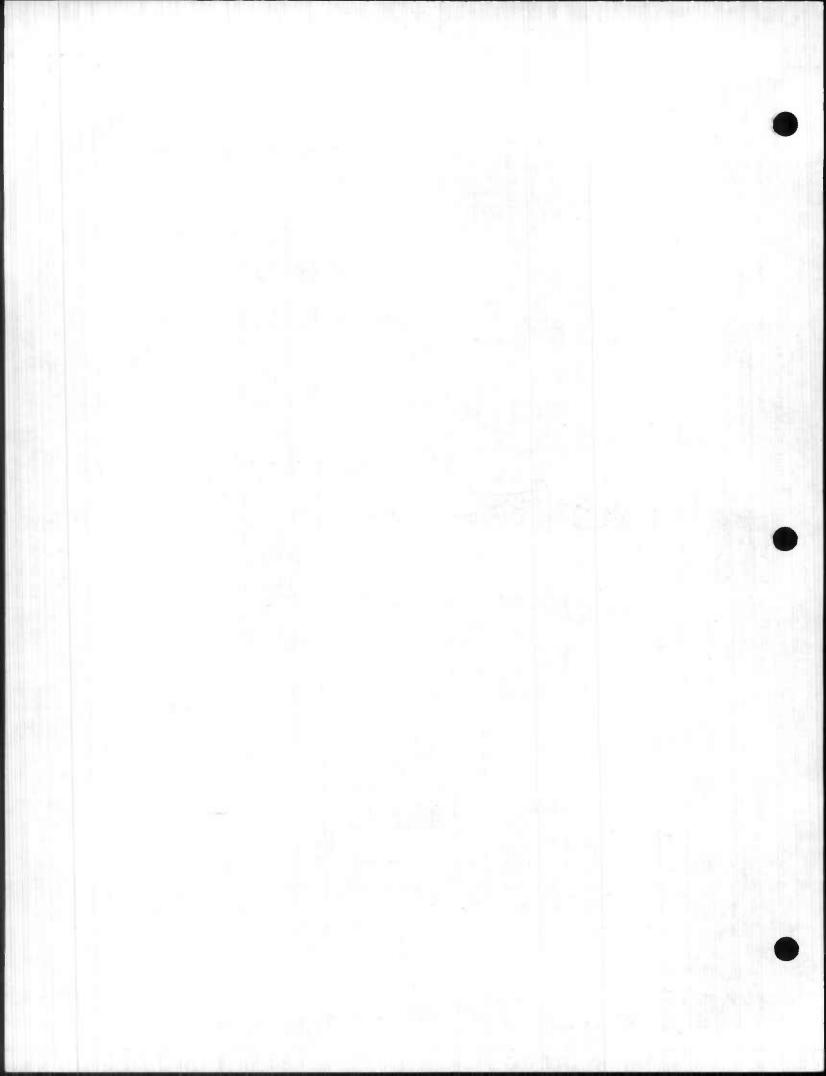
APR 1



# Please Type or Print In Black Indeiible Ink. Assure All Copies Are LegIble.

ITEM #	State of Maryland 26 PER MD G782 4/11/00 AH	Department of Certificate o			ene 00	11651				
	Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death				
Physician	LYLE OLWIN	FOS	TER	APRIL	9, 2000 Year	2:30 PM				
Medical/ Examiner	4a Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	4c. County of Deat	h				
	CHESAPEAKE HOSPICE HOUSE		LINTHI	CUM	ANNE AR	UNDEL				
al or	5. Social Security Number 6. Sex 7. Age (In yrs. In	Months Day		8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)				
	220~07~7911	82 Yrs.		JULY 18	, 1917 MAR	YLAND				
	the same of the sa	, Town or Location				10d. Inside City Limits				
Director	MARYLAND ANNE ARUNDEL	SEVERN				1 ☐ Yes 2 🕅 Mo				
ě	10e. Street and Number	10	g. Citizen of What Co	untry?						
ě	7958 TELEGRAPH ROAD	21	144		U.S.A.					
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dacedant Evar in U,s Armed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Speciban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W					
1190	15. Decedent's Education	16a. Decedent's Usual Occ	cupation	ina 1	6b. Kind of Business/	Industry				
Completed	Elementery/Secondery (0-12) College (1-4or 5+)	(Specify only highest grede completed)  Elementery/Secondery (0-12)  College (1-4or 5+)  (Give kind of work done during most of wo								
Š	17. Fathar's Nama (First, Middla, Last)	STEEL WORKER	18. Mother's Neme		FEDERAL GC	VERNMENT				
o Be		STER	MARY	e (First, Middle, M	HOSE					
-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stre	eet and Number or Rura	al Route Number,	City or Town, Stete, 2	Zip Code)				
	KEVIN DOUGLAS SEARS (NEPHEW)	1110 COURT	REVERE, OD	ENTON, M	ARYLAND 21	113				
	20a. Method of Disposition 20b. PI	ace of Disposition (Name of emetery, cremetory or other p	nlacal	Date 2 PR. 13.	Oc. Location - City or	Town, State				
		N HAVEN MEMOR			GLEN BURNI	E, MD.				
	21. Signature of Funeral Service Licensee.	22. Name and Add	dress of Facility SI	NGLETON	FUNERAL HO	ME, P.A.,				
	1 Dules	1 SECOND	AVENUE, S.V	W., GLEN	BURNIE, M	D. 21061				
н	23a. Parti. Enter in diseasa, or complications that caused the death shock, or him hiture. List only one cause on each line.	. Do not enter the mode of o	dying, such es cardiac d	or respiratory arre	st,	Approximate Interval Between				
г	Immediate Cause (Final					Onset and Deeth				
	disease or condition resulting in death)	90	Troples	un		1 year				
ler	Due to (or	as a consequence of):	0							
Examiner	Sequentially list conditions  Due to (or	as a consequence of):								
	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Einter Underlying									
Cal	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot):									
Physician/Med	d									
1YSK	Part II. Other significant conditions contributing to death but not resu	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								
by Ph		7 1 1 5 31		1 Yas Sho 3 Probably 4 Unknown						
	resolt in			24a. Wes an		Were autopsy findings				
Completed				perform		available prior to completion of cause of death?				
1				1 □ Ye		1 ☐ Yes 2 ☐No				
000	25. Was case reterred to medical		26. Place of Death							
0	examiner?  1   Yes 2   40   Hospitel: 1   Inpatient 2   E	ER/Outpatient 3 DOA	0.1		nee 6 NOther (Spe	city) HOSPICE				
	27. Menner of Death 1 Natural 5 Pending 28s. Date of Injury (Month, Dey Year)	Injury V	njury at Work?	28d. Describe ho						
Cath	2 Accident Investigation	M 1	Yes 2 No							
STURE .	4 Homicide determined 28e. Place of Injury - At hot building, etc. (Specify,	me, tarm, street, tectory, offic )	CB	28t. Location (Str. City or Town,	reet and Number or R , State)	urai Houte Number,				
5	29a. Cartiflar 12 Certifying Phyalcian: To the best of my know	viedge, death occurred at the	time, date and place	and due to the co	use(s) and manner as	s stated.				
edical Certification:	(Check only one)	on and/or investigation, in m	y opinion, deeth occurr	ed at the time, da	ite and place, and due	to the cause(s)				
	29b. Signalate and title of certifier	29c. Lice	ense number	29	d. Date signed (Mont	h, Day, Year)				
		0	18508		4-10-	00				
	30. Name and addrass of person who completed cause of death (Item									
	Charles JWUMD 1600 50	rain thuy th	106 Glen	Burnie	MO 21	061				
ate	31. Data filed (Month, Dey, Year) 32. Registrar's Signat	ure & board								
strar	APR 1 1 2000 Janeira	D popul	4							

DHMH 16 Ray 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Day FROCK, SR. 7, 2000 5:45 AM THOMAS APRIL 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth HANOVER ANNE ARUNDEL LOT 9, CHESAPEAKE MOBILE PARK If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Dete of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F Yrs 55 MARYLAND 218-42-6191 FEB. 3. 1945 Usual Residence of Deceden 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits 1 ☐ Yas XXNo MARYLAND ANNE ARUNDEL HANOVER 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? LOT 9, CHESAPEAKE MOBILE PARK 21076 U.S.A. 14. Race - American Indien, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Stetus 12. Was Decedant Ever in U,S. Armed Forces? Black, Whita, atc. 1 ☐ Yas 2 🛣 No If Yas, Giva 1 Nevar Married 2K Married Specify: WHITE 1 ☐ Yas 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 10 TOUR BUS OPERATOR TRANSPORTATION 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) FROCK MARY HAGAN WITI-TITAM 19e. Informant's Name/Relationship (Type, Pnnt) 19b. Meiling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) LOT 9, CHESAPEAKE MOBILE PARK, HANOVER, MD. 21076 MARY FROCK (WIFE) 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4/10/ 4 □ Donation 5 ♣ Other (Specify ENTOMBMENT CEDAR HILL CEMETERY 2000 BROOKLYN PARK, MD. 21. Signatura of Funeral Sa 22. Nama and Address of Fecility SINGLETON FUNERAL HOME, P.A., Licensee MO1138 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 0 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initioted evants resulting in death) Last Dua to (or as a consequence of): Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Yes 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Deeth (Check gnly ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 1 Inpatient 2 ER/Outpatient 3 DOA Hesidanca 6 ☐Othar (Specify) 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d scribe how injury occurred 5 Pending invastigation Neture 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be 3 Suicide

The law requires that the death certificate be executed Box 68760. P.O. Records, of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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r than "natural", or item or Medical Examiner

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**Physician** /Medical

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29b. Signe

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Pages 1 end 2 should be nent of Heelth end Mental

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filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

Physician: Division or Attending Hospital 25

within 24 hours a completely

DHMH 16 Ray 6/95

State Registrar

M. D 31. Data filed (Month, Day, Year) 2000

30. Nama and address of person who completed cause of death (Item 23a) Type, Print)

32. Registrar's Signetura

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

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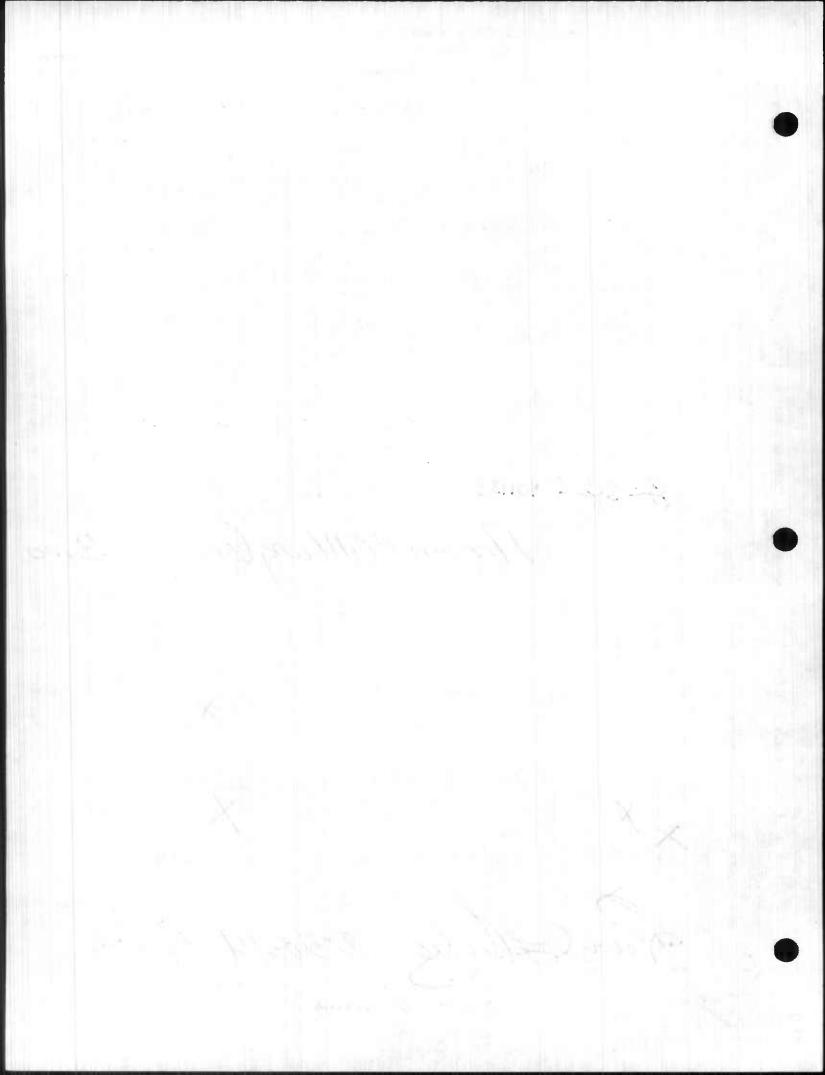
rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause of the cause

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

, and due to the cause(s)

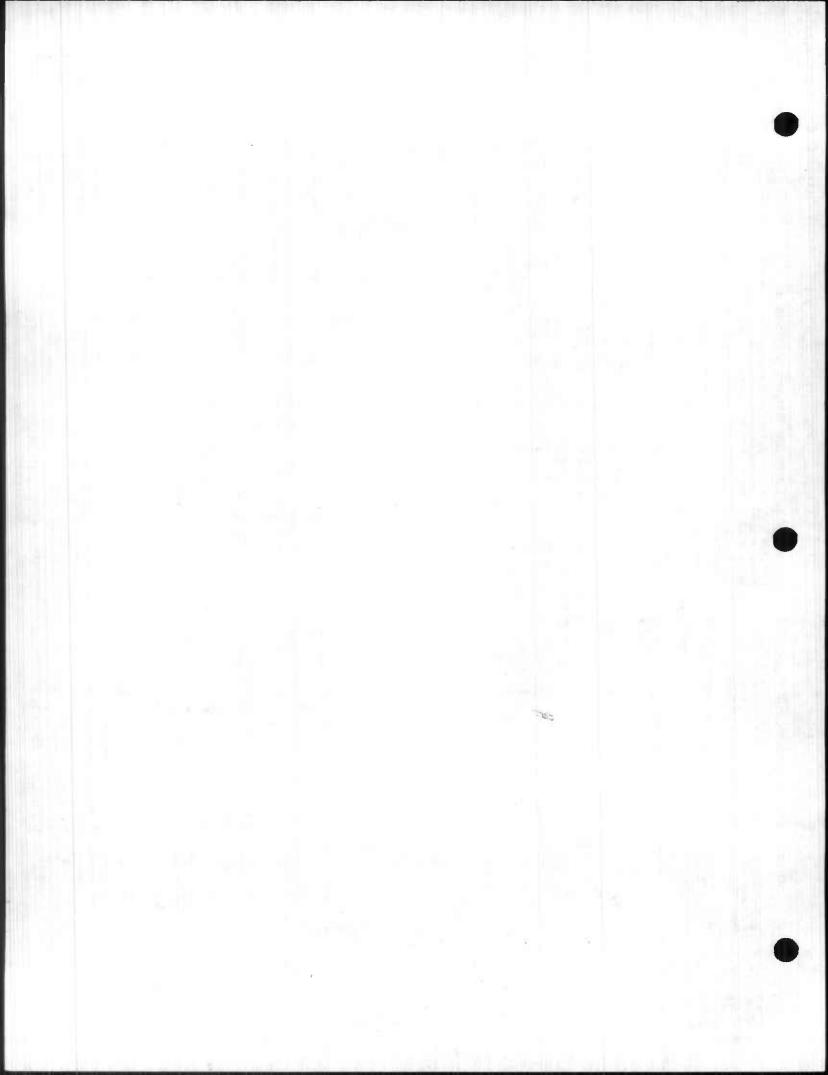
signed (Month, Day, Year)



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Box 68760,
P.O.
Records, I
f Vital
Division of

		State of Ma	aryland /	Certifica		lealth and l Death		giene () Reg. No.	0 11653		
	Name (First, Middle,	Last)					2. Date of De		3. Time of Death		
MICI	HAEL	JEROME	FL	LOWER	5 3	SR,	APRIL	OBY 2	Vear 000 12:251		
4e Facility Nem  G / L  5. Social Securi  2/5-52  Usuel Residence	CHR 15 6 2-0655		PICE (In yrs. last b		er 1 Year	4b. City, Town, or  BALT  If Under 24 Hrs.  Hours Min.	MORE	th y, Year)	of Death  N / A  9. Birthplace (State or Fore Country)  M ARYL A		
10a. State	10b. County		10c. City, To	wn or Location					10d. Inside City Lim		
MARILA 10e. Street and	HUO	NIA		BI	ALT	IMOR	E Ci	7	1 Ø Yes 2 □		
10e. Street and	0			10f. Z	ip Code			10g. Citizen of V	Vhat Country?		
0/0		NNIE BR				2120	8		SA.		
11. Merital State	,	12. Wes Decedent I Armed Forces?		13. Was Deci	edent of H ecify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)		e - American Indian, k, White, etc.		
	Married 2 Merried ed 4 □ Divorced	d 1 Tyes 2 1 N If Yes, Give Year or Detes:	10	1 ☐ Yes	2 No	Specify:		Specify	BLACK		
	15. Decedent's	Education	16	a. Decedent's Us	uel Occup	ation		16b. Kind of Bu			
Elementery/S	Specify only highest ( Secondery (0-12)	grade completed)  College (1-4or 5	+)	(Give kind of w life. DO NOT	ork done use retired	during most of word)	king				
Elementery/S 17. Father's Ne		ZVRS		ENEFIT	RE	PRESENT			RANCE CO		
17. Father's Ne	me (First, Middle, La	nst)	<i></i>					Maiden Sumam	(e)		
	S Name/Relationship	- (Time Orien)		LOWER		DELC		0'h T	CHIN		
À	2 AH EIN	p (Type, Print)	~ 18			end Number or Ru					
20a. Method of		WERS (WI	20b. Plece	of Disposition (Na ery, cremetory or	arme or		Date 1	20c. Location -	MD. 2120 City or Town, Stele		
Immediate Cau disease or con- resulting in dea	use (Final dition	0.	ng c	ANCE oconsequence of	~				Onset and Death		
Sequentially lis	t conditions,	b	Due to (or es a	consequence of	):				1		
Cause. (Disease)	e or Injury	c									
Part II. Other ale	th) Lest	d	Oue to (or es e	consequence of)	):						
Part II Other el	onificant conditions	contributing to death bu	t not resulting	in the underlying	CSUSA Giv	en in Part I	23h Did	Johacco usa con	ntribute to the cause of dec		
Tartii. Other si	grinteant corrections	Contributing to death of	t not resolute	ni die diloenyng	Cause giv	on ar Fait i.			3 Probably 4 Unkn		
							24a. Wes perfo	an autopsy rmed?	24b. Were eutopsy finding available prior to completion of cause of death?		
							101	Yes 2KINo	1 ☐ Yes 2 ☐ No		
25. Was case referred to medical 26. Place of Deet								h (Check only one)			
axaminer?	2 <mark>M</mark> No	Hospital:				4 LI Nursing h		dence 6 XOthe			
axaminer?	math	28e. Date of Injur (Month, Dey	Year) 280.	Time of Injury M	28c. Injur Wor	k? Yes 2 □ No	280. Describe i	how injury occurr	ed		
axaminer? 1 Ves 2 27. Mennar of D 1 Natural	5 Pending	tion			nı office		28f. Location (S City or Tox		er or Rural Route Number,		
axaminer? 1 Yes 2  27. Mennar of D 1 Natural 2 Accider 3 Suicide	5 Pending investiget	t be 28e. Place of Inju	ry - At home, I	farm, street, facto	ly, onlo		Only or ror	vii, Diario/			
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DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 02 Year AL 2000 :30 PM APRIL 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE | If Under 24 Hrs. | B. Date of Birth | Hours | Min. (Month, Day, OLN RIVE A.A. COUNT 9. Birthplace (State or Foleign Country) MARYLAND 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Months 10 M 2□ F Days 218-24-591 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No GLEN BURNIE A. COUNTY MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? INCOLN DRIVE USA. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 20 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) ONTRACTOR CONSTRUCTION MANAGEMENT GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALTER MILDRED HAMILTON 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DR. GLEN BURNIE MD, 21060 Date 20c. Location - City or Town, State (WIFE) 475 LINCOLN THELMA FORD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition LABurial 2 Cremation 3 Removal from State HILL COMETERY 04-08-00 GLEN BURNIE, MD. 4 ( Openation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JOSEPH H. BROWN 2140 N. FULTON AV JR. FUNERAL HOME FULTON AVE BALTIMORE, MO. 21217 23a. Par /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory effect, and the caused the death. Approximate intervat Between Onset and Death Immediate Cause (Final (townach 15 Month diaease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 → Wilknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 2 ☐ Accident

Examiner physician and the burial-tren Box 68760. P.O. signed by t Records, certificate Division of Vital this or Attanding 24 hours after death. Director: /

Examiner Physician/Medical à Completed Be 10 Certification:

edical

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ahow

5 Nerns 23s

"natural", or

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Itam 27 Is marked other than ".

Department of Important: If he any injury or o

**Physician** /Medical

Baltimore, Maryland 21215-0020

Director

Funeral

ģ

Completed

Be

Lo

1 Yes 2 No 27. Menner of Death

3 ☐ Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical examiner?

5 Pending Investigation 6 Could not be determined

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

Location (Street and Number or Rural Route Number, City or Town, State)

Glen Burnie, MD. 21061

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Man\_M.D

D 39505

29d. Date signed (Month, Day, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) ndhash Markan Crain 1600

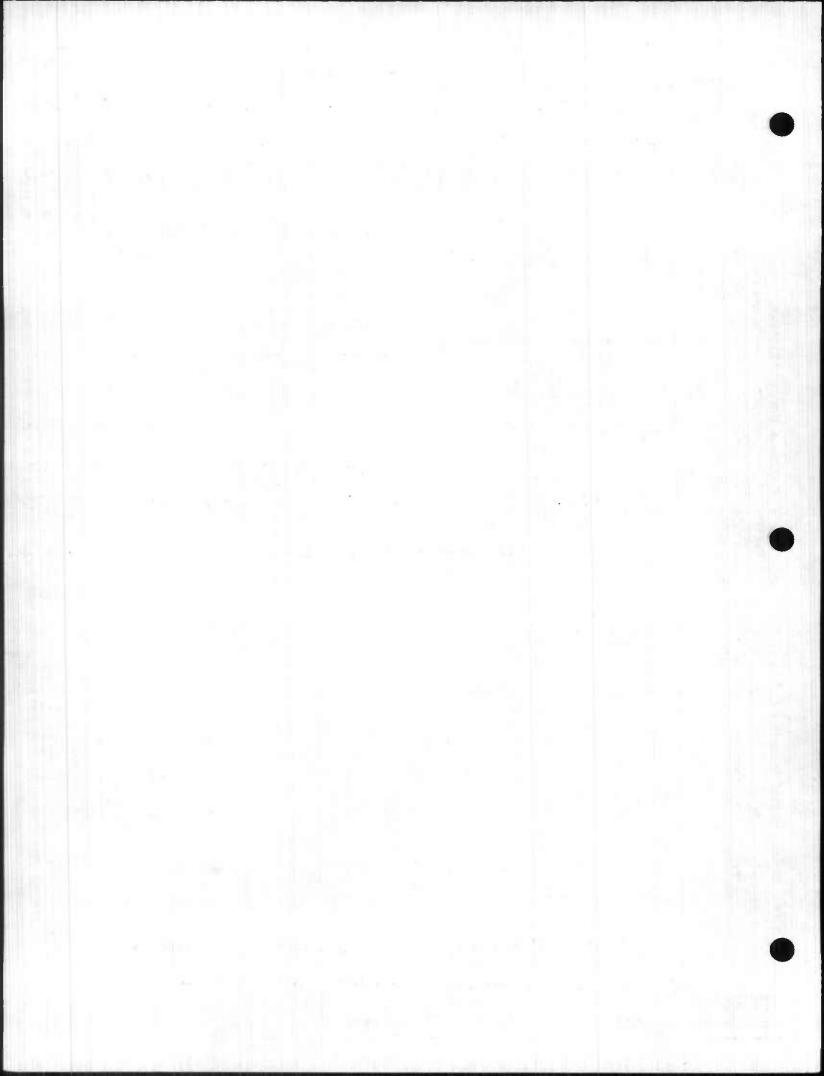
31. Date filed (Month, Day, Year)

2000

32. Registrar's Signature

**DHMH 16 Ray 6/95** 

within 24 hour



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Gorden H. Fisk 1 ISTA A 9'20 A.M 2000 0 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner HOSPITAL BALTIMORE ST. AGNES **Baltimore City** | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 5, 1908 5. Social Security Number 6 Sev Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Yrs. 91 Director 071-10-2087 Usual Residence of Deceden r 28e-f show 10a State 10h Count 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yesx2 ☐ No Director Howard Ellicott City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o filed within 72 hours after death with is all Hygiene.
I other than "natural", or hams 23s or invent, the Medical Examinar must be a 21042 U.S.A 10365 Tuscany Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes X No Specify: Specify: py White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry tool & die Elementary/Secondary (0-12) College (1-4or 5+) machinist permit. Pages 1 and 2 should be filled v. Department of Heelth and Mental Hygier Important: if tem 27 ia marked other th any injury or other traumatic event, that ones. 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Fisk Elizabeth Buckley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10365 Tuscany Road Ellicott City, Maryland 21042 Mr. Jay Fisk Son 20b. Plece of Disposition (Name of cometery, crematory or other plece)
West Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, Stete th☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 04/10/2000 Painted Post, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility MOIII3 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part I. Enter the discusse, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock or heart latture. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ACUSE CARDIOUASCULAR ACCIDENT UNICHOUN Examiner Due to (or as a consequence of) Examine HYPEIZIENSION UNICNOUN physicien and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that installed as a condition). Due to (or es e consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or es e consequence of) Part II. Other algrificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 YUnknown PROSTATE CANCER by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy Completed DIMBENES MELLITUS 1 Tes 2 No 1 Yes 2 No DEMENTIA Vital 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Napatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural or Attending 5 Pending investigation 2 ☐ Accident 1 Yes 2 No after death. 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletally filled in b edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contilion MD. P12592 APIZI'L 6 2000

Registrar
DHMH 16 Rev 6/95

State

GORDBY

AME

900 CATON AUE, BALTIMONE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

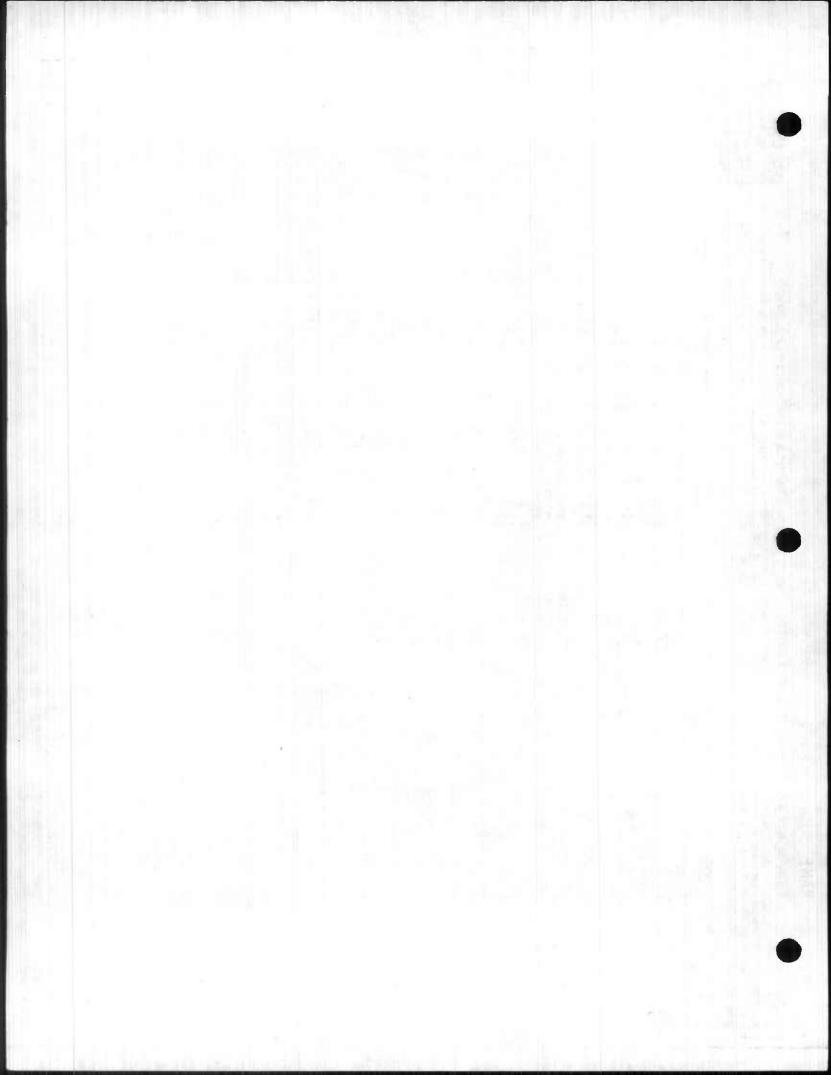
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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

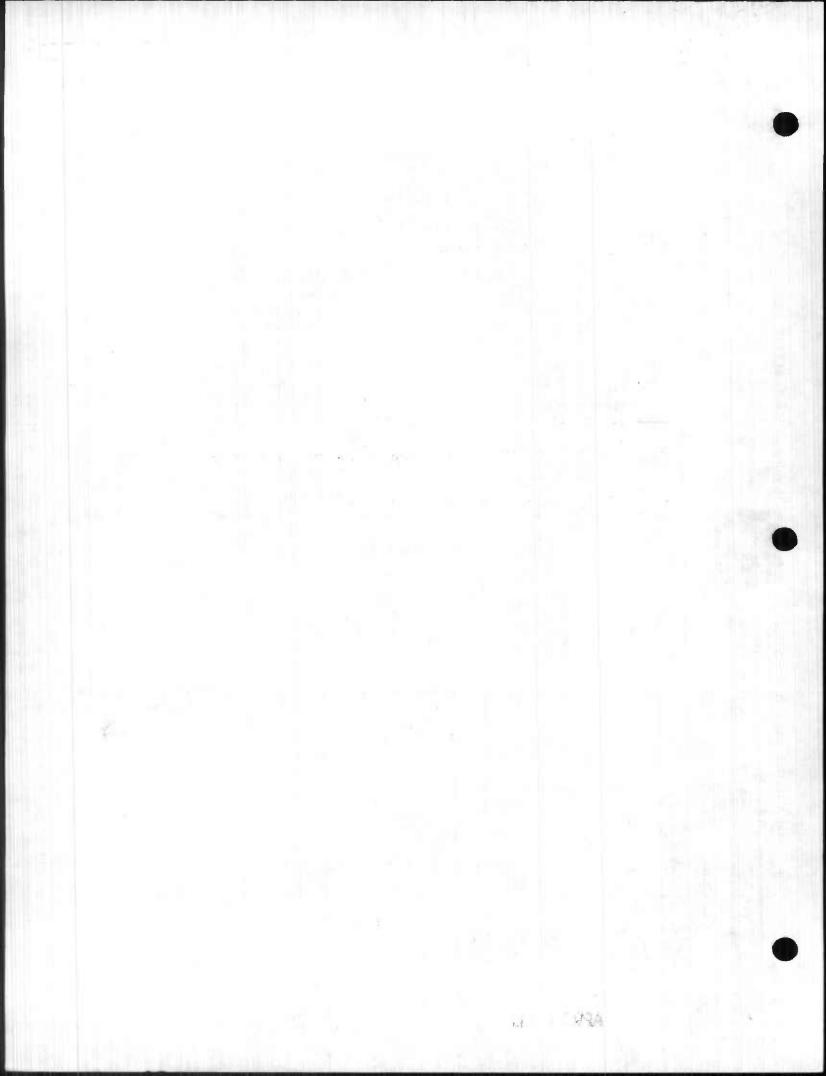
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State of Maryland / Department of Health and Mental Hygiene 0 1 1 5 5 6

	d ITEM#19a perFHG		JOO EW	Certificate of		2. Date of Deet		3. Time of Death
Physician /Medical	JOSEPH			FLEISCHE	ER .	APRIL 8		11:00 AM
Examiner	4a Facility Neme (If not institution, g 7203 ROCKLAND	the second of th	E #208		4b. City, Town, or Lo BALTIMORE	ocation of Death	4c. County of BALTIMO	
Funeral Director	5. Sociel Security Number 6. 214–16–6410		e (In yrs. last birtl	hday) If Under 1 Yeer Months Deys	If Under 24 Hrs.	8. Date of Birth (Month, Day, APR • 23,		9. Birthplace (State or Foreign Country) N.Y.
yland M M	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location				10d. Inside City Limits
with the Maryland a or 28e-f show be notified at Director	MD BALTIMO	RE	BAL'	TIMORE				1 ☐ Yes 2 No
23a or 2 unit be no	10e. Street and Number 7203 ROCKLAND	HILLS DRIVE	#208	10f. Zip Code	21209	10	U.S.A.	net Country?
urs after dos alr, or items Examiner m by Fune	11. Meritel Stetus  1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 2 Yes 2 1 N If Yes, Give Yeer or Detes:	TATE T	13. Was Decedent of If Yes, specify Cul	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. WHITE
ygiene. Nr. the Medical. Completed	15. Decedent's (Specify only highest g Elementery/Secondery (0-12)	Education rade completed)  College (1-4or 5	i+)	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retine	pation during most of work ad)	16b. Kind of Busi		
	17. Father's Neme (First, Middle, Las	st)	AC	COOMITAINI	18. Mother's Name	e (First, Middle, N		
rice averaged out	SAMUEL	E	FLE:	ISCHER	EMMA			BARRON
ls me	19e. Informant's Neme/Reletionship			Mailing Address (Stree				
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Depart Import any in	21. Signeture of Funerel Service Lic	ensee	~	22. Neme end Addr	SOL	LEVINSO		S., INC. E, MD 21208
vsician	23a. Pert1. Enter the diseese, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the deeth. Do no					Approximete Intervel Between Onset and Death
Medical kaminer	Immediate Cause (Finel disease or condition	. 4	ympl	noma				Year3
100	resulting in deeth)	a	Due to (or as e co	onsequence of):				1
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certificate has irector, page 2 Be Comp	25. Wes case referred to medical axaminer?				26. Place of Deet	h (Check only on	e)	
H H	1 Yes 2 No	Hospitel: 1 Inpatie		patient 3LI DOA		me 5 Reside		
Affer a fune	1 Naturel 5 Pending 2 Accident investigeti	(Month, Dey		jury Wo	ork? Yes 2 No	200. Describe in	w injury occurre	
at Director: After the funeral Certification:	3 Suicide 6 Could not determine	he	ury - At home, feri :. (Specify)	m, street, fectory, office		28f. Location (St. City or Town		r or Rurel Route Number.
within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certificat	29e. Certifier 1 Certifying P	thysician: To the best of	examinetion end	deeth occurred et the t /or investigetion, in my	ime, dete end place, opinion, death occurr	end due to the cared et the time, da	use(s) end men ate and place, ar	ner es stated. nd due to the cause(s)
omple Omple	29b, Signature and little of certifier	and menner ste	a Ch	29c. Licen	se number	2	9d. Dete signed	(Month, Dey, Year)
0/	1 Demare	200	LE .		4543	2	April	9,2000
13	30. Name and address of person who	completed cause of de	Sath (Item 23a) (1	Come Daint)	11955 MI			1112
	01007100		201.0	10000				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Deeth **Physician** Month Yeer SYDNEY E. GREEN 9:20 A.M 04 00 09 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BON SECOUR HOSPITAL BALTIMORE N/A 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 9-13-1916 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** Deys 1□M 2 F Months Hours 217-22-4587 83 Yre. Director Usuel Residence of Decadent the Maryland 10e. Slate 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Mar Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f si any Injury or other traumatic event, the Madical Examinar must be notified. 1 ☐ Yes 2 ☐ No Director N/ABALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2121 WINDSOR GARDEN LN. 21207 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 2□No ve X Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) -12-College (1-4or 5+) -0-HOUSHIELD STOCK CLERK 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be SAMUEL E. SMITH SYDNEY JACKSON 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROLAND GREEN (HUSBAND) 2121 WINDSOR GARDEN BALTO.MD 21207 20e. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete LOUDON PARK 1 Durial 2 Cremetion 3 Removel from State 4-13-2000 BALTO.MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of FacilityBAILEY FUNERAL SERVIC 1721 N. MONROE ST. BALTO. MD21217 ernon 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Deeth Physician /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequenca of): P.O. Box 68760. Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? director, page 2 should be detant 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Division of Vital Records. þ Be Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? this certificate P Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certificalelefy filled in by the funeral director. 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 npalient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. To the I 29b. Signature end title of cartifie 29d. Dale signed (Month, Dey, Yeer) 4 30. Name end eddress of person who comp ed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

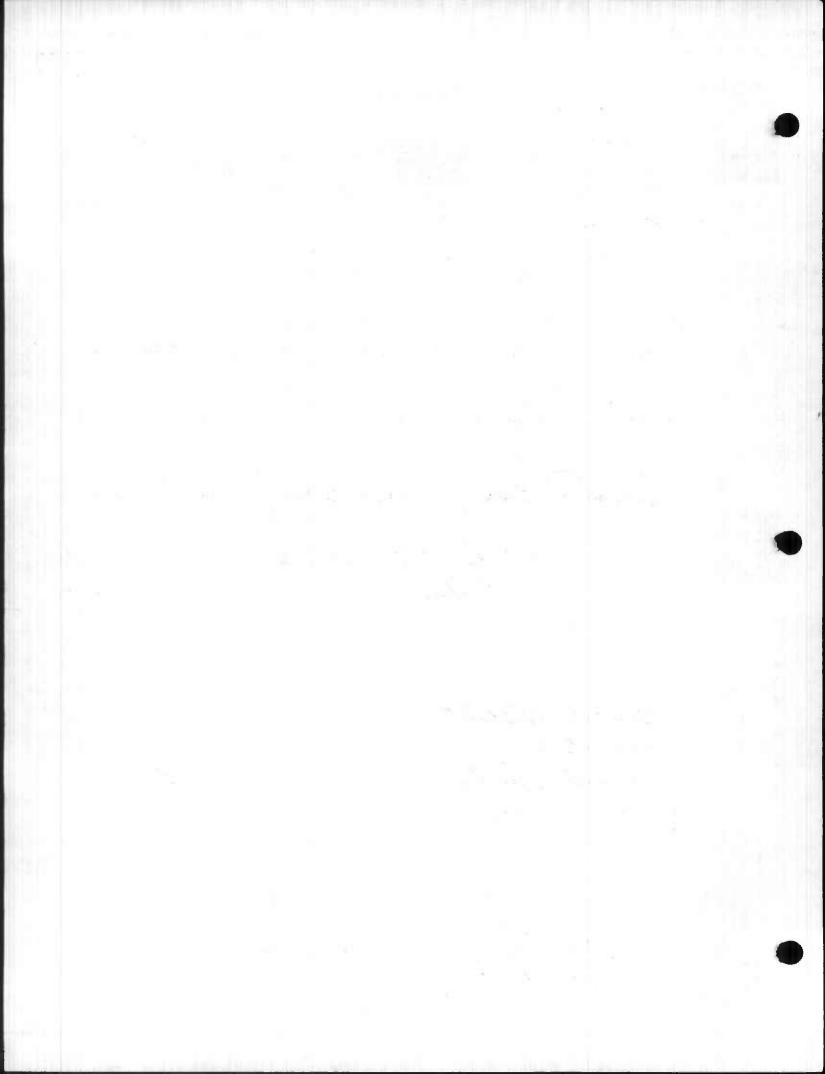
State

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31. Dete filed (Month,

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State of Maryland / Department of Health and Mental Hygiene

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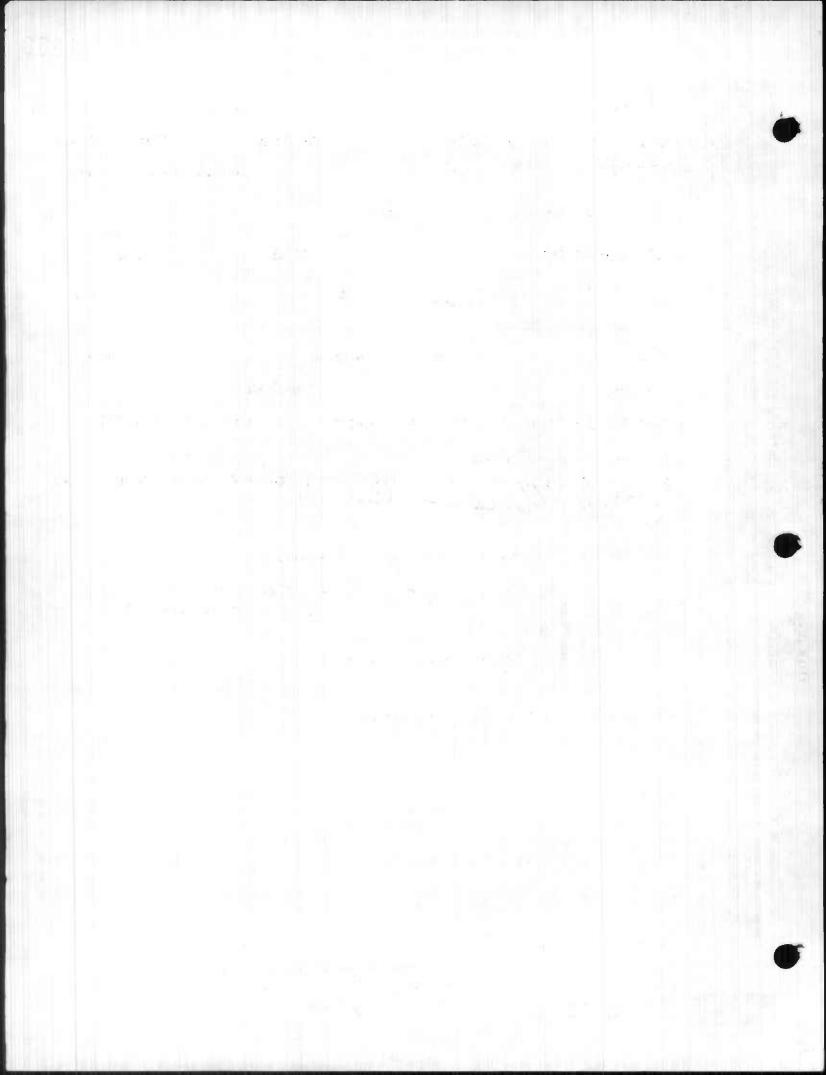
Certificate of Death 2. Deta of Deeth 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) Month **Physician** THEODORE GENELLA MARCH 15, 2000 19:37 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Undar 1 Yaar | if Undar 24 Hrs. Months | Days | Hours | Min. 8. Data of Birth (Month, Day, Yaer) Jan 23, 1941 6. Sex 1 M 2 F 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 49 unknown Director Usual Rasidence of Decedant 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shor treumstic event, the Medical Examiner must be notified at Prince Georges Cheverly 1 ☐ Yas 2X No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3003 Hospital Drive 20785 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 □ Yas 2 □ No If Yas, Giva Yaar or Datas: unknown Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. Pages 1 end 2 should be filed within 72 hours after in ent of Health and Mentel Hygiena. nnt: if Item 27 ie marked other than "natural", or ite 1 Nevar Marriad 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fether's Nama (First, Middla, Last) unknown unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 20785 Prince Georges Hospital Center 3001 Hospital Drive Cheverly, MD other 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata Department of Important: If it any injury or or pncs. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ② Othar (Specify) In State 21. Sonature of Furnal Sonoto Licensed dy, /Director 22 Nama and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201

Letter the disease, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or respiratory arrast, make or heart failure. List only one cause on each line. Approximate interval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) a. Respiratory Failure
Dua to (or as a consequence of): Examiner Stage Chronic Obstructive

Dua to (or as a consequence of): Pulmonary Disease Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseese or Injury that initiated evants rasulting in daath) Last Physiclan/Medical Dua to (or as a consequence of): Ventricelar Vachycardia Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, P. Hotery Disease 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of daath? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician:
 24 hours effer deeth.
 Funeral Director: Affer this certific. funeral director, 25. Was casa referred to medicat examiner?
1 ☐ Yes 2 ☑ No 26. Placa of Daath (Check only one) Be Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 27. Menner of Daeth 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No investigetion 2 Accidant 3 Sulcide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, dete and placa, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Cartifiar (Check only one) within 2 To the 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar Nancy Kalpana Giron Aty MD 20052848 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) NANCY K. TIMOTHY uce Landover Hills

32. Ragistrer's Signature Ly 74 th Avenue MD 20784 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1659 Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Day 2000 Physician MARCH 31, 10:25 AM MARGARET HENLEY /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Apt 13K 1027 Cathedral Street Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□ M 2 F 76 Yrs. 217-6-657 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show be notified at W3 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23s nedral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 21 No If Yes, Give Year or Detes: 11. Maritel Status Race - American Indian, Bleck, White, etc. a filed within 72 hours after al Hygiene. other than "natural", or its 1□ Yes 20 No 1 Never Married 2 Married Specify: Specify: Blac à 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) paraprofessional school system 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sûmeme) Be 2 should be financial by and Mental b haso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If hen 27 is in any injury or other traun place. 6202 Catalpha Rd Baltimore, MD 21214 Sandra Wilson/daughter 20b. Piece of Disposition (Neme of cemeters, cremetory or other s 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State tomul 4 Donation 5 Other (Specify) 20000 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Romald S. Wade, Birector Street art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Myocardial Examiner thy perfensive disease Examiner attending physician and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last per tension Physiclan/Medical Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructive lune 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidenca 6 Other (Specify) 1□ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident or Attendation of the death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier (Check only one) Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2 To the F 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Dey, Yeer) APR 11

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1000 Carnedrel street - Brito MD 21201

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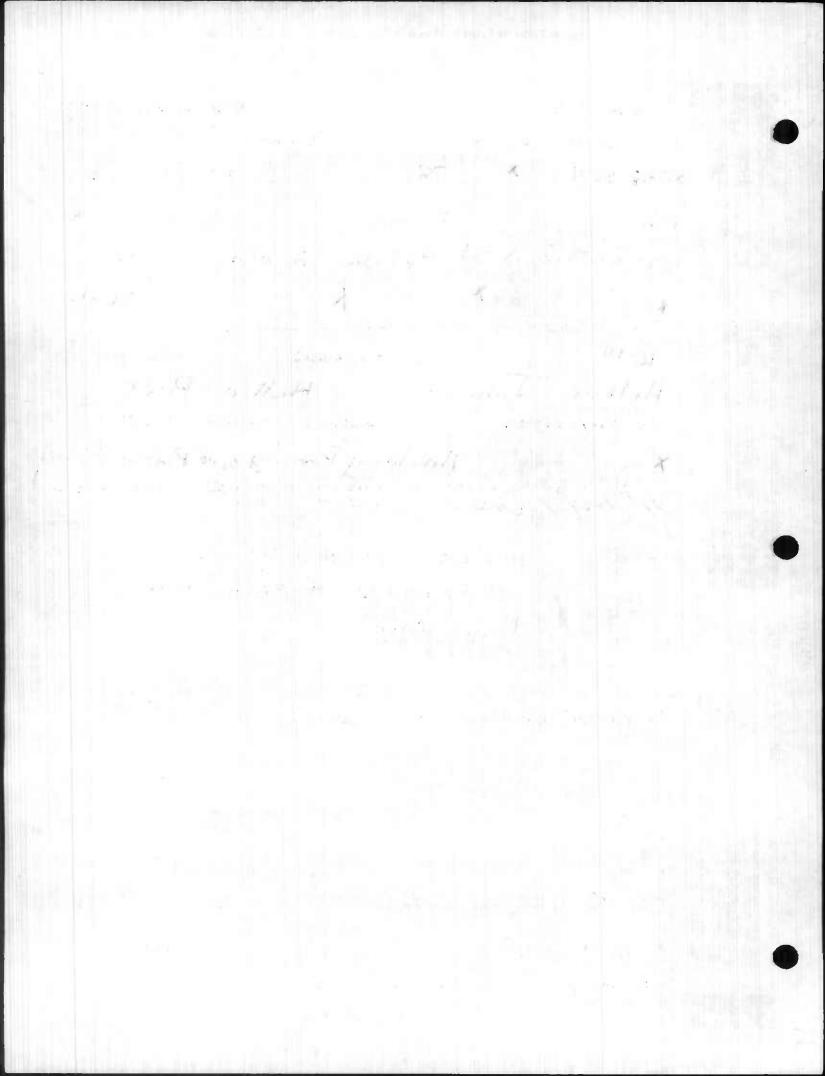
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DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O.

death.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2000 April 5, 8:20AM Physician Neva S. House /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1215 Haverhill Road Violetville N/A H Under 1 Year 7. Age (In yrs. last birthday) 84 Yrs. If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□M 2⊠F 238-05-9919 Yrs Director April 8, 1915 N.C. **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits than "natural", or liams 23s or 28s-f show the Medical Examinar must be notified at MD Violetville NA 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1215 Haverhill Road 21229 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indien, 11 Merital Status Black, White, etc. 72 hours after 1 Yes ZN No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 tNo Specify: White Specify: 3 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hydren Important: If flem 27 is marked other tha any injury or other traumatic event, <u>Ital</u> 2008. Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 88 Ralph B. Simmons Effie E. Dellinger 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonya Thomas, daughter 1935 Grant Rd. Halethorpe, MD. 21227 20b. Place of Disposition (Name of commetery, crematory or other place)

MD National Memorial Park 4-8-00 Laurel, MD 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel othma disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burlal-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or es e consequence of): physician a the burlat Box 68760. an/Medical Due to (or es e consequence of): 88 980 Physicia signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown by should 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to Completed completion of cause of death? has page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this funeral ( 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 1. Netural 5 Pending investigation Ne Hospital or Attending in 24 hours after death. Ne Funeral Director: After 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 2 4 D Homicide filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. compietely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

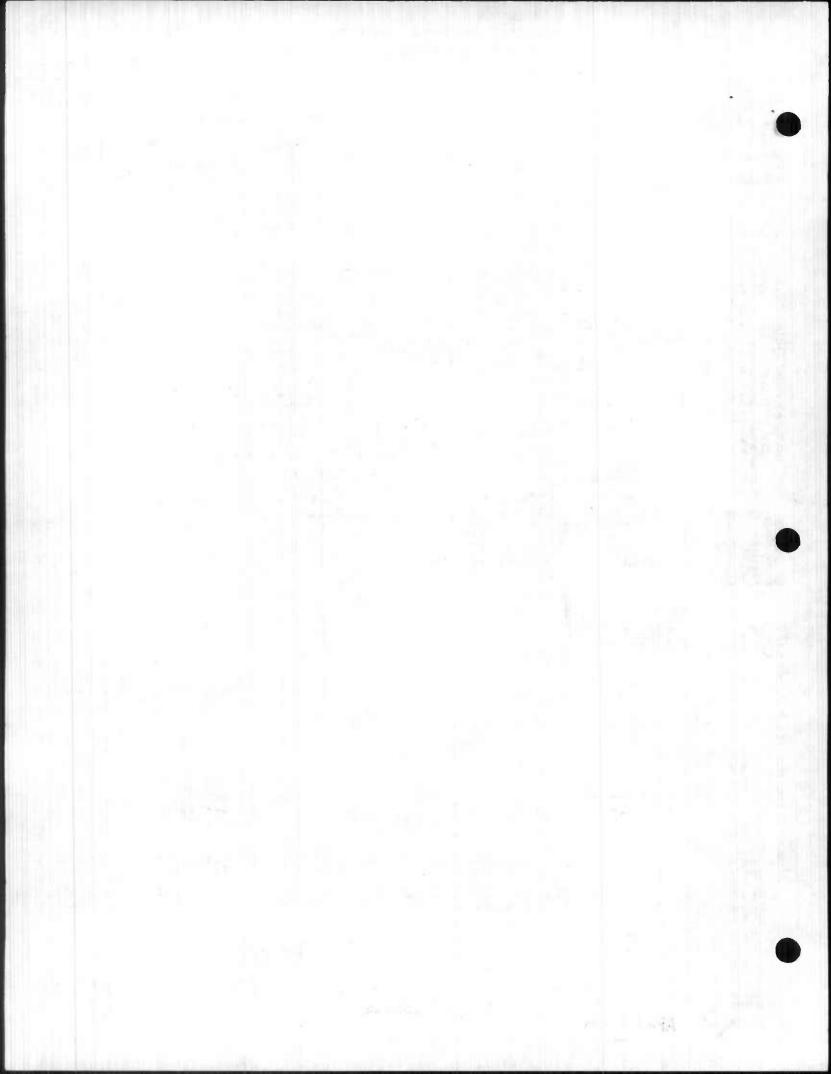
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Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

1120 NPalling Road Cathrille MO 21228 J.W. Ceck (VMX) 32. Registrar's Signature oaks

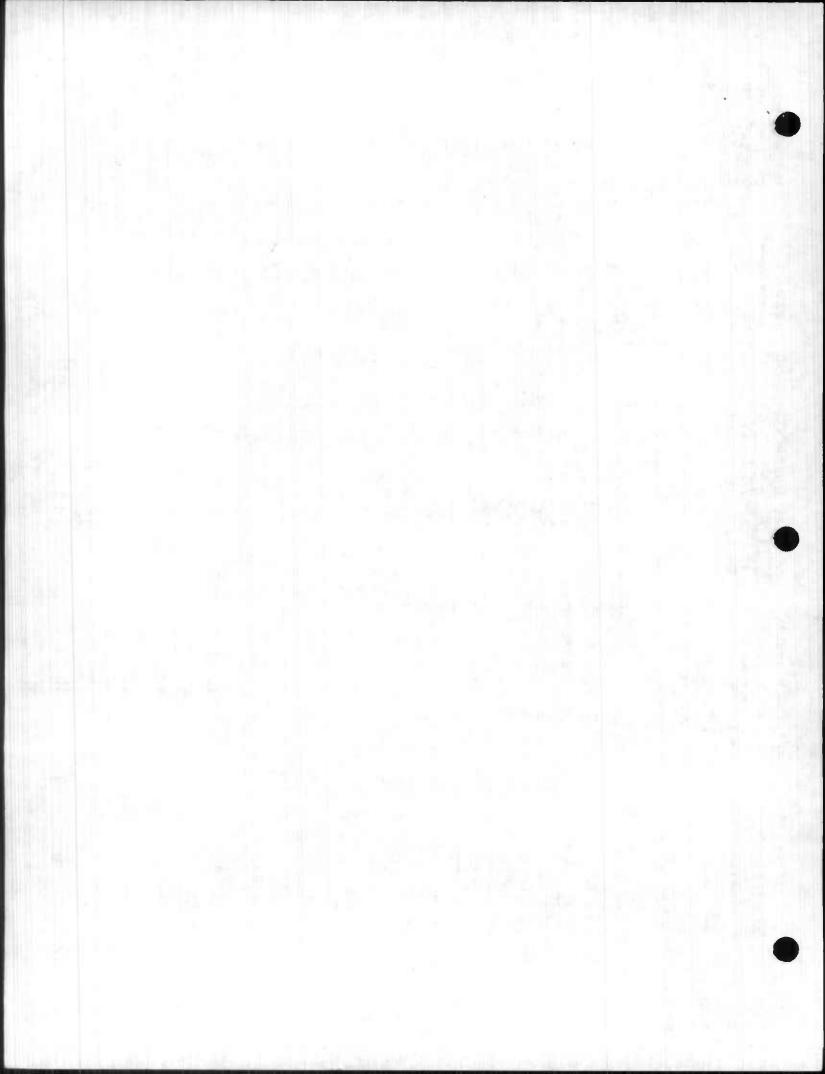
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Division

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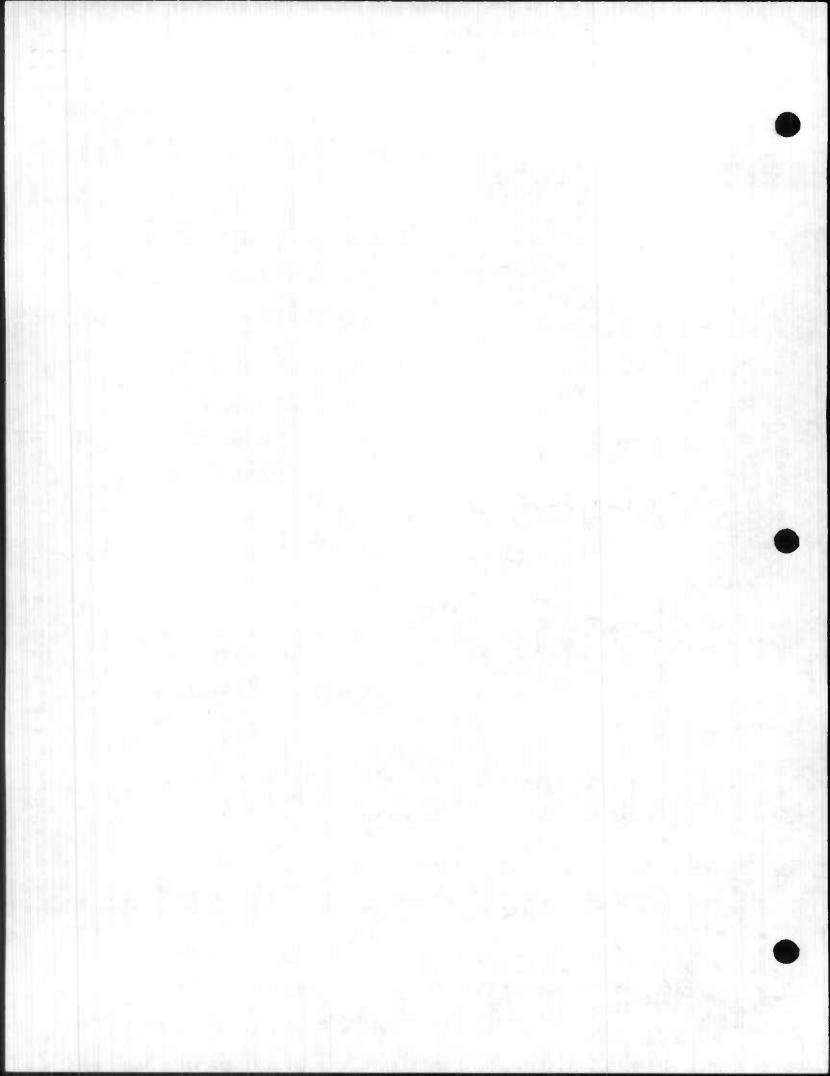


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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First)	, Middle, Last)			Cenii	icate of	Death	2. Date of De			3. Time of Death
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or 28a-f s be notified Director	10e. Street and Number	LCIMOLC		Darcimo		Of. Zip Code			10g. Citizen of W	Vhat Count	ry?
		ills Ro	ad		2	21229			USA		
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effeat Exami		3 ₩ Widowed 4 Divorced If Yes, Give Year or Dates:					Specify:		Specify.	White	9
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To Be	Walter Wink	kler					Wilhel	menia (	Cooper		
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death HANNERS A port HARY 10.33 PER 2000 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Harborside - Harford Gardens If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Months Daye 214-22-4018 87 Yrs June 17, 1912 Baltimore, Md. Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City 1X Yas 2 No N/A Md. 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 21214 3018 Ailsa Avenue United States 12. Was Decedent Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent'e Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Saleslady Shoes (Retail) 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Telitha S. Bowers James E. Rufenacht 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 3018 Ailsa Avenue Baltimore, Maryland 21214 Curtis W. Hanners Sr. (Husband) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4/13/00 Maryland Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funaral Sarvice Licensaa Milton J Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 21214 5305 Harford Road Baltimore, Maryland death. Do not enter the moda of dylng, such as cardiac or respiratory arrest, 23a. Part1. Enter the disarted or complicate shock, or heart failure. List only one di Approximate Intervat Between Onset and Death Immediate Cause (Final diseese or condition resulting In death) 10 Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 CUnknown 24a. Was an eutopsy performed? 24b. Were eutopsy findings available prior to completion of causa 1 Yes 2 No 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 T Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 2066 ( 29b. Signature and title of cartifier

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Examiner

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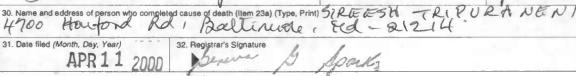
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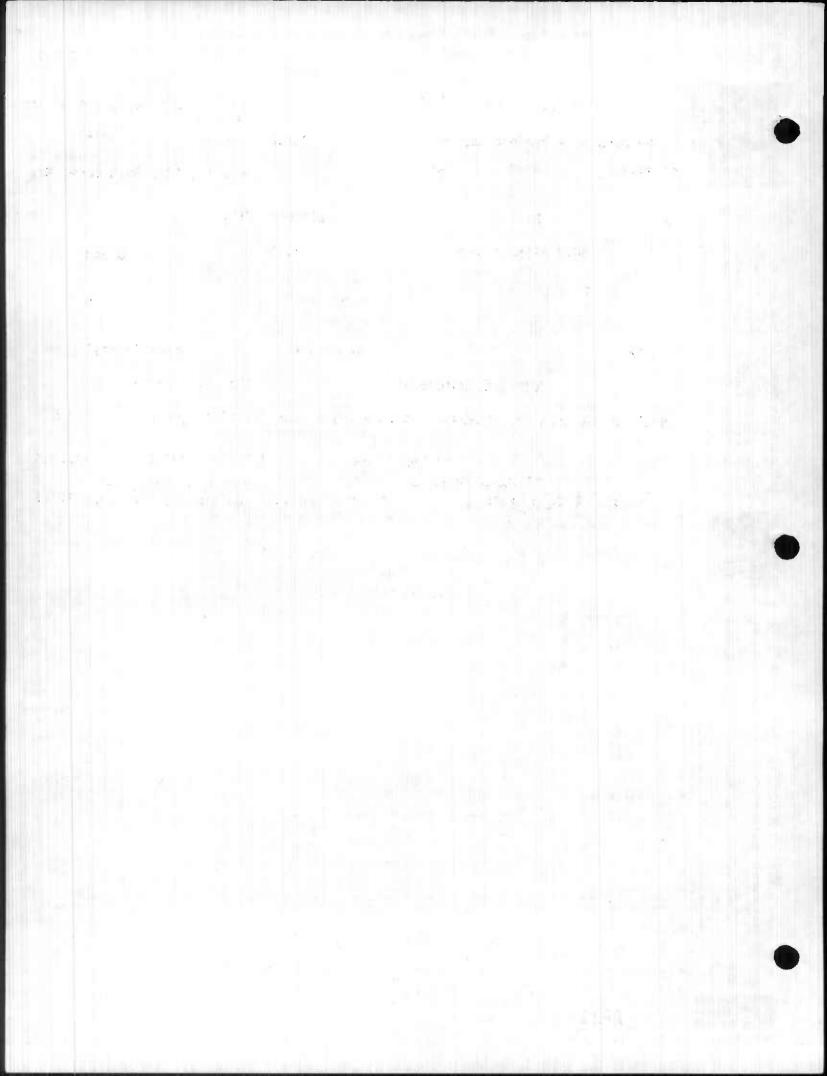
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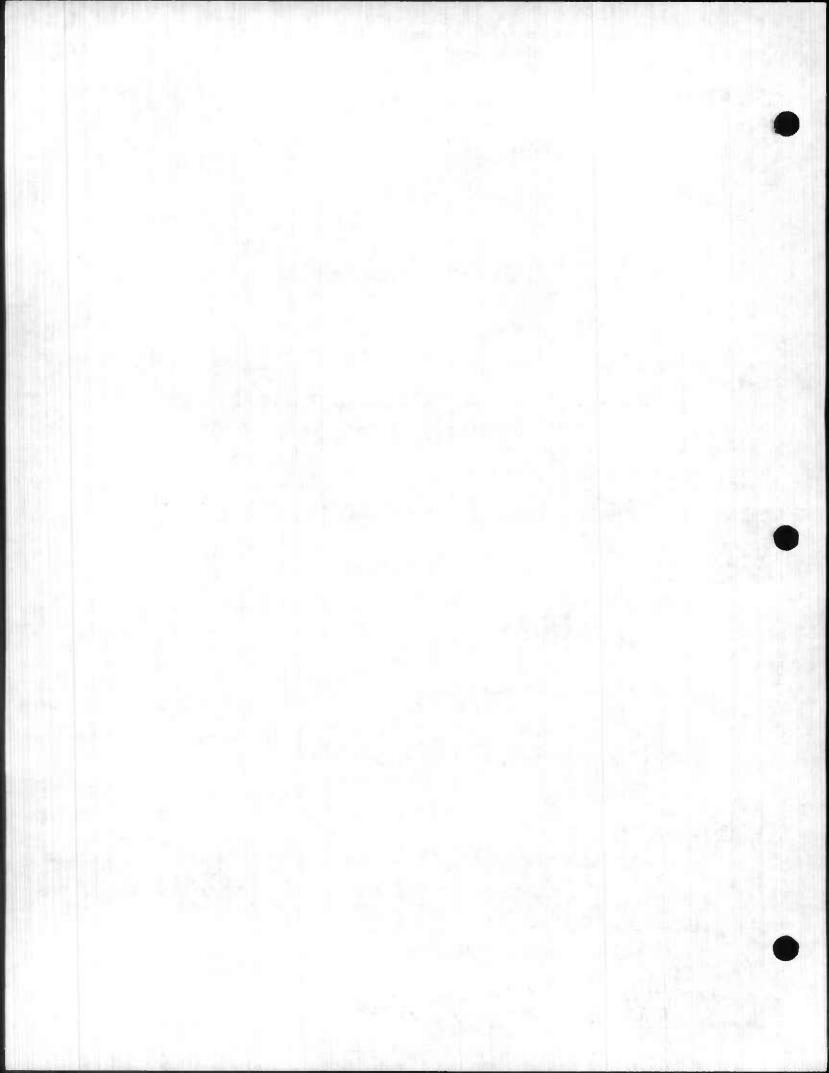
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State of Maryland / Department of Health and Mental Hygiene 0 0 | | 66 l

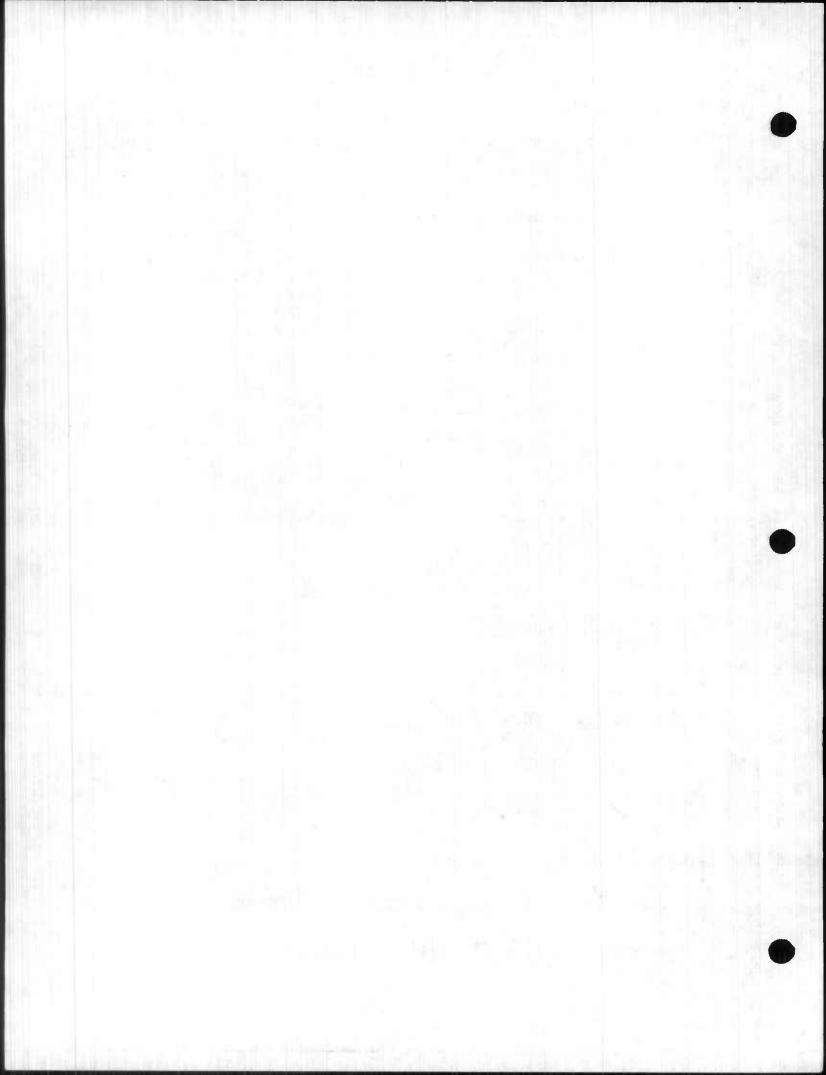
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DIVISION To the Hospital or Attance within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	(Check o		miner: On the basis of exam and mannar stated.							
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State Registrar	APF	4 4	32. Registrar's S	D A	salls	•				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Earl April 1.40PM Hawkins 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Center Hospital Baltimore Harbor N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1 X M 2 7 F 212 01 7778 92 Yrs. Nov. Director 10, 1907 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 25a-f show notified at Baltimore 1 Yes 20 No Maryland Anne Arundel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or flams 23s or the Medical Examiner must be r 286 E. Hillside Terrace 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: ğ 3 ₩ Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if hem 27 is marked other than in any Injury or other trauments. Elementery/Secondary (0-12) College (1-4or 5+) 12th Mechanic Royal Typewriter Co. 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be George W. Hawkins Maggie LaBarre To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Ronald Hawkins 126 Longfellow Drive Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 4/13/00 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Md. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Week Dehydration Examiner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last certificate be exec Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by POOV of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed The law page 2 certificate has 2 to No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Mannet of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: s after death.
I Director: After is on by the funer After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T HomicIde To the Hospital o within 24 hours af To the Funeral Di completely filled is 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and titleyof certifier 29c. License number 29d. Date signed (Month, Dey, Year) nanas bay 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Southhanover St, Baltimore, MD Bakleh, 4001 Mohanad 31. Date filed (Month, Dey, Year) APR 1 1 2000 32 Registrar's Signature

**DHMH 16 Rev 6/95** 

State Registrar

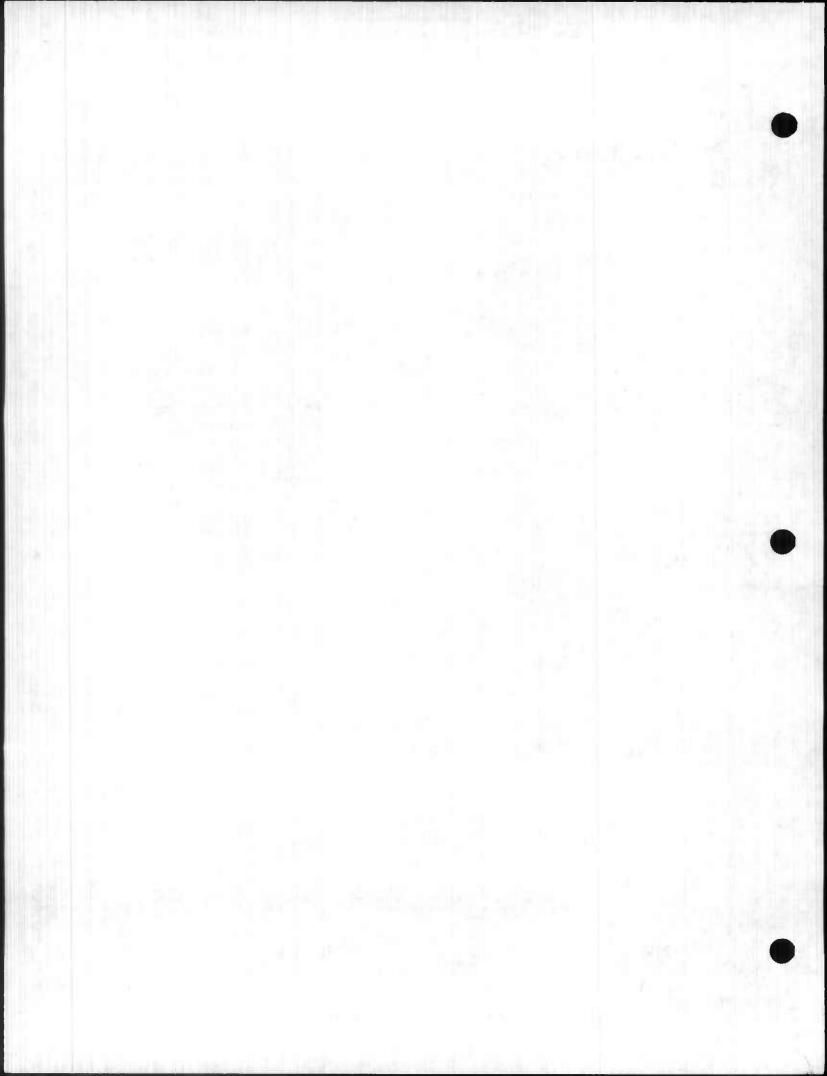


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State of Maryland / Department of Health and Mental Hygiene 00 | 1666

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Physician /Medical	1. Decedent's Nama (First, Middle, L	hoffman	1 1	R.			2. Data of Do Month APRIL	Day	Year	3. Time of Death 9:03 P.M	
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Funeral Director	5. Social Security Number 6. 220 12 7300 Usuat Residence of Decedent	AND A COL	n yrs. last birtho	Months	Days	If Undar 24 Hr. Hours Min		th ay, Year) 6, 1925	Country	ce (State or Foreign y) yland	
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2 should and Men la marke aumatic	19a. Informant's Name/Retationship		19b. N	Mailing Address	(Street	and Number or F	Rural Route Numi	ber, City or Town	, Stete, Zip C	(ode)	
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At: # #	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Contents)	Removal from State	cemetery,	orematory or off	ran	Cem.	A/11/00	20c. Location		Maryland	
pemit. Pa Departmen Important: any injury	21. Signature of Funeral Service Lice	nsee		22. Name and			Gonce l	Funeral			
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104	30. Name and address of person who	1N. 300	1,50		141	HOVER	STREE	T. BAL	rimore	E. MD 2122	
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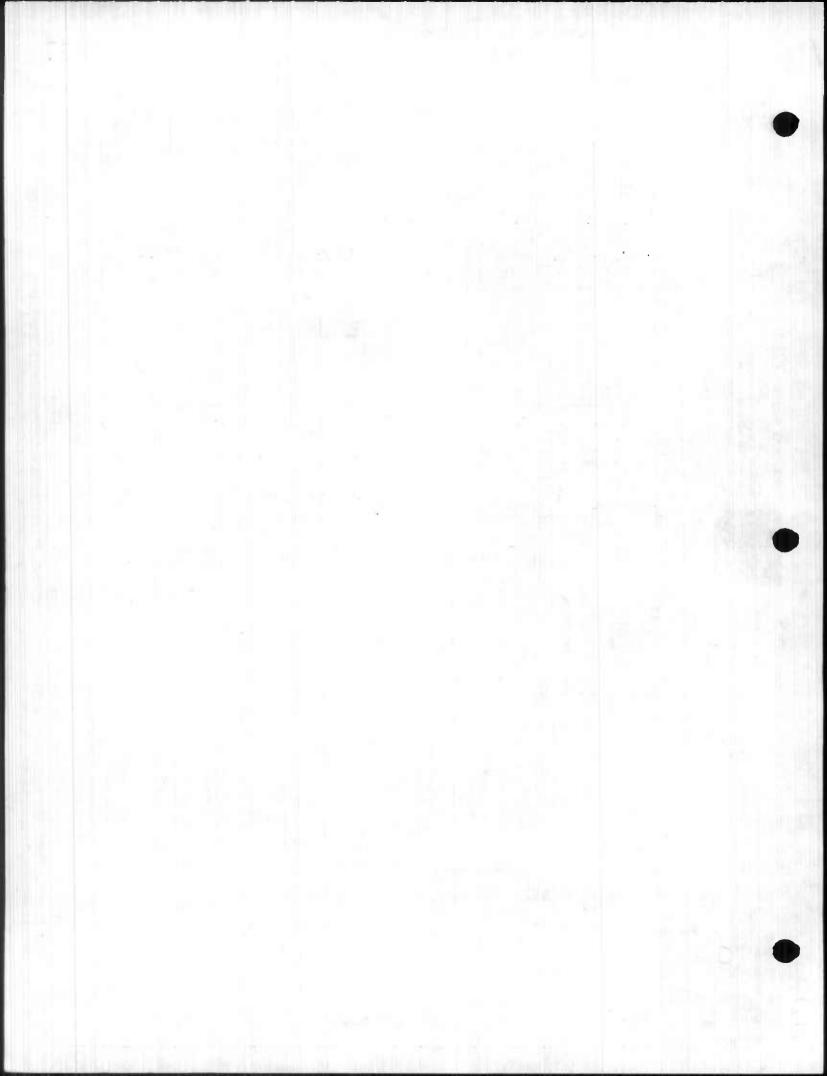
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- DHMH 16 Rev 6/95

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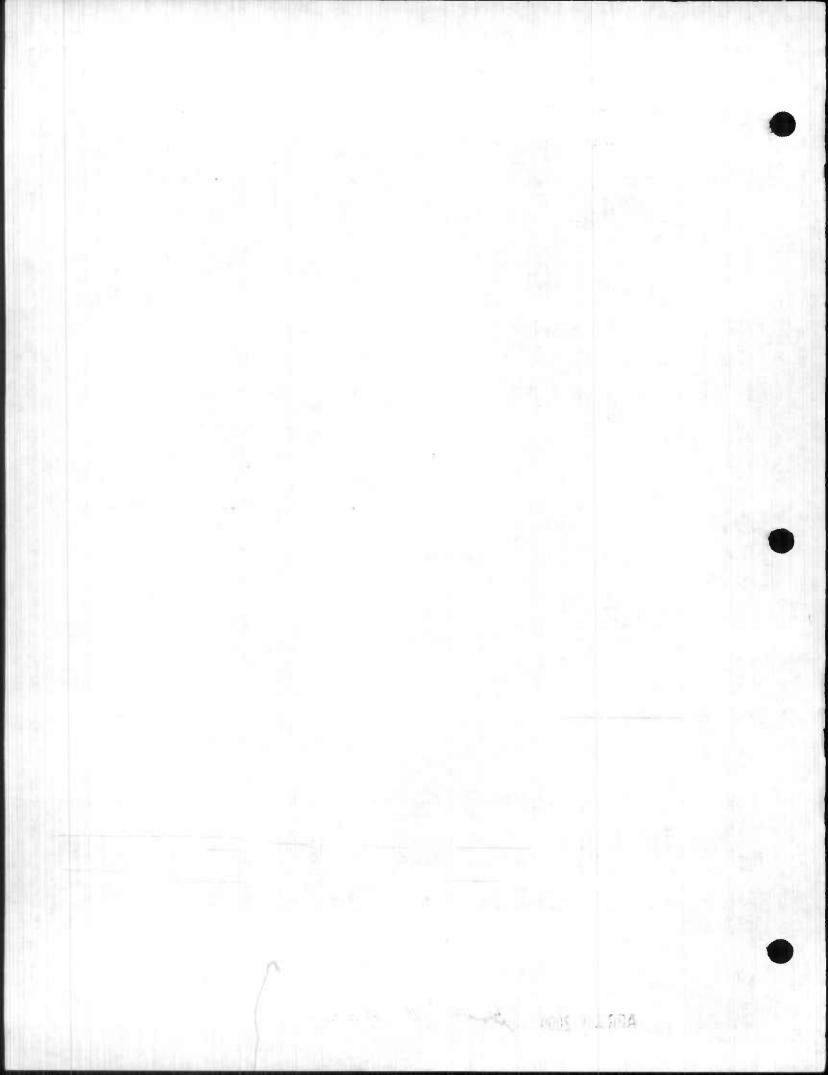
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32. Registrer's Signeture



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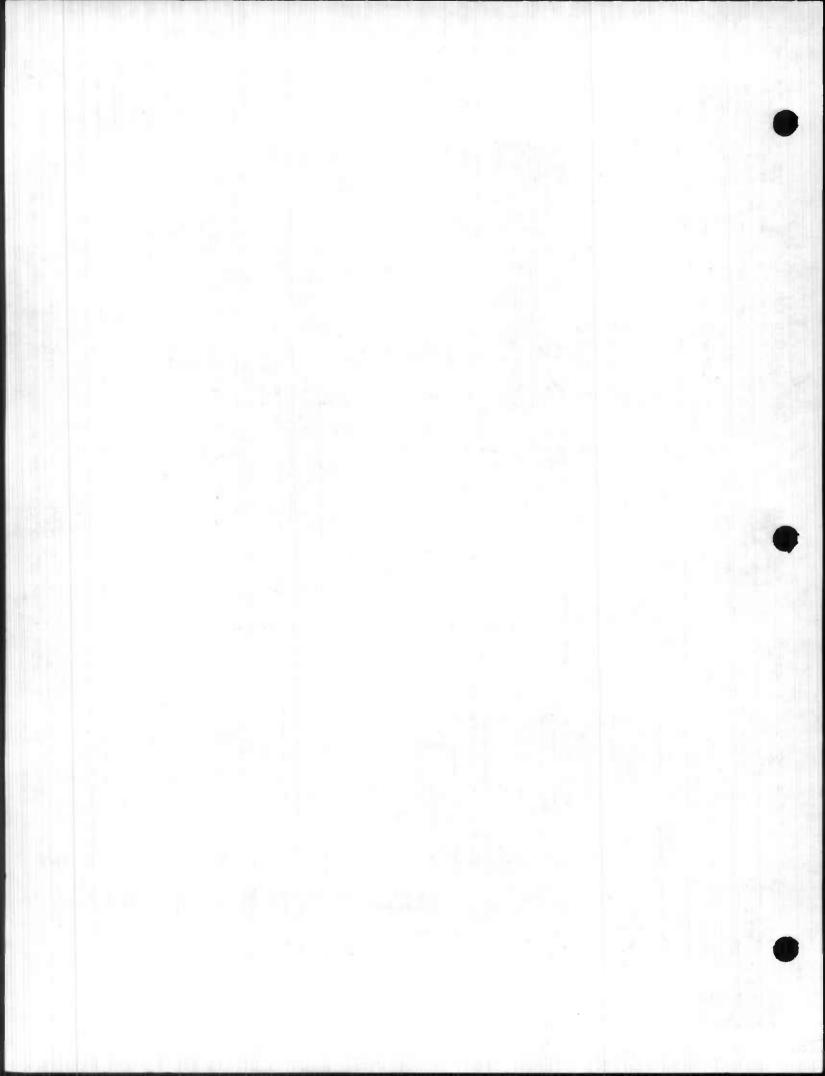
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decegent's Neme (First, Middla, Last) 2. Dete of Death Year **Physician** Johnson Artha ,2000 Lucille /Medical 4c. County of Death 4e Facility Neme (If not institution, one street and number) 4b-City, To of Death Examiner Age (In yrs. last birthday) If Under 24 Month, Day, Year) Social Segurity Number 6. Sex 9. Birthplace (Stata or Foreign /, Country) **Funeral** 1□M 20 F 212-16-8692 une 18, 1905 Director Virginia Usuel Residence of Decedant 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No Director HARY land none 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2906 USA 21215 Nortolk Aue. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify. P AMER CAL 3 Widowed 4 □ Divorced Yeer or Detes 16b. Kind of Business/Industry Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nant of Health and Mental Hygiene, wit: if Nem 27 is marked other then " Elemantary/Secondary (0-12) College (1-4or 5+) HOSPITAL 124 lerk MERCY 17. Father's Neme (First, Middle, Last, 18. Mother's Name (First, Middle, Meiden Surname) Be Rev Doiled -John 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Fown, State, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) BAILIMOR, Md 21215 2906 aunt NORTOIK Ave Rma 20b. Piece of Disposition (Neme of cemptery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete Department Important: If 11/2000 Memorial Parky AR butus MARYland 4 □ Donation 5 □ Other (Specify) butus of Funerel Service Licensea 22. Name end Address of Facility NAncy m. WA 3405 W. MANKlin St. Baltimore, MARYOR 21229 llace The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and niture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Fine MYOCH HOUR disease or condition resulting in deeth) WISACTON Examiner Due to (or es a consequence of): Examiner ころらとにうかりて while use cy work DICENCE SO WENTE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last and Dua to (or as a consequence of) 30 yerrik 68760, be- monthery 131かかって MOW ensura Physician/Medical the Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 20PNo 3 Probably 4 Unknown 0 Division of Vital Records. à 24b. Wera autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Nes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Panding investigation 1 Netural 1 Yes 2 No death. after death Director: 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 112 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) Medical 29a. Certifier end menner steted. 29b. Signature and sitle of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of parson who completed cause of deeth (Item 23e) (Typa, Print) 0 3100 ButuBA m mo ion 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** Mildred pari (0) 30 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner mor If Under 24 Hrs. 5. Sociel Security Number If Linder 1 Year 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Birthplece (State or Foreign (Spuntry) **Funeral** Months Days 28-110 Hours 10 M 2 F Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director mor land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Nerns 23s or 30 Funeral d death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indien 11 Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 1 If Yes, Give Yeer or Detes: 2 No Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify à 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 if item 27 is marked other or other traumatic avent Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meider Be Health and Mental 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of cometary, cremetary, or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or ott pages. 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 □ Other (Specify) dia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ose Enter the displace, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, for heart fellure. List only one cause on each line. d. Approximate Interval Between Onset end Deeth **Physician** /Medical Severe Demen Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 21/No 1 Yes 3 Probably 4 ☐ Unknown should be det Records, þ Be Completed 24b. Were sutopsy tindings eveilable prior to completion of ceuse of death? 24a. Wes en autopsy performed? page 2 2 0 No certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 12 No Medicai Certification: To 1 Yes 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After Neturel 5 Pending 1 Yes 2 No death. investigation 2 Accident 24 hours after deal Funerel Director: 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 6 filled in Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and menner stelled. (Check only one) the th 29b. Signatury and title of certified 29c. License number 29d. Date signed (Month, Day, Year) To 2000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) APR 1 1 32. Registrer's Signeture State 2000 Zeper Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death **Physician** April 20000 EVELYN KUESTER 14:20 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner University of Maryland Medical System Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 10/22/1912 Birthplece (State or Foreign Country) **Funeral** 1 M 2 X F 213-10-6633 Director Maryland Usual Residence of Decedent The Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show N/A Baltimore 1 ▼ Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? man be a 2209 W. Pratt St. 21223 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene.

Int. If Rem 27 is marked other than "natural", or its uy or other traumatic event, the Medical Examins. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretery Clothing Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surname) Be Henry H. Kuester, Jr. Mary Schaefer 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. James, Jr. / nephew 6221 Parkview Ct. Elkridge MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stata Department of Important: If any Injury or Loudon Park Cemetery 4/6/2000 Baltimore, Maryland 4 Denation 5 Qther (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 23a. Part1. Entar the disease, or complications that caused shock, or heart failura. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximete Intarvsl Between Onsal and Death **Physician** /Medical Immediate Cause (Final Immediate Asystole disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical 5 Due to (or as a consequence of): 20 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by i 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? hes page 2 1 Yes 2 No certificate 1 Yes 2 No of Attending Physicien: effer death. Director: After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 X No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in to the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records,

21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Registrar

BRian 31. Date filed (Month, Day, Year)

APR 11

29b. Signature and title of certifie

Browne M.D 22 S. Greene St, Baltimore, Md 32. Registrar's Signature

Browne Mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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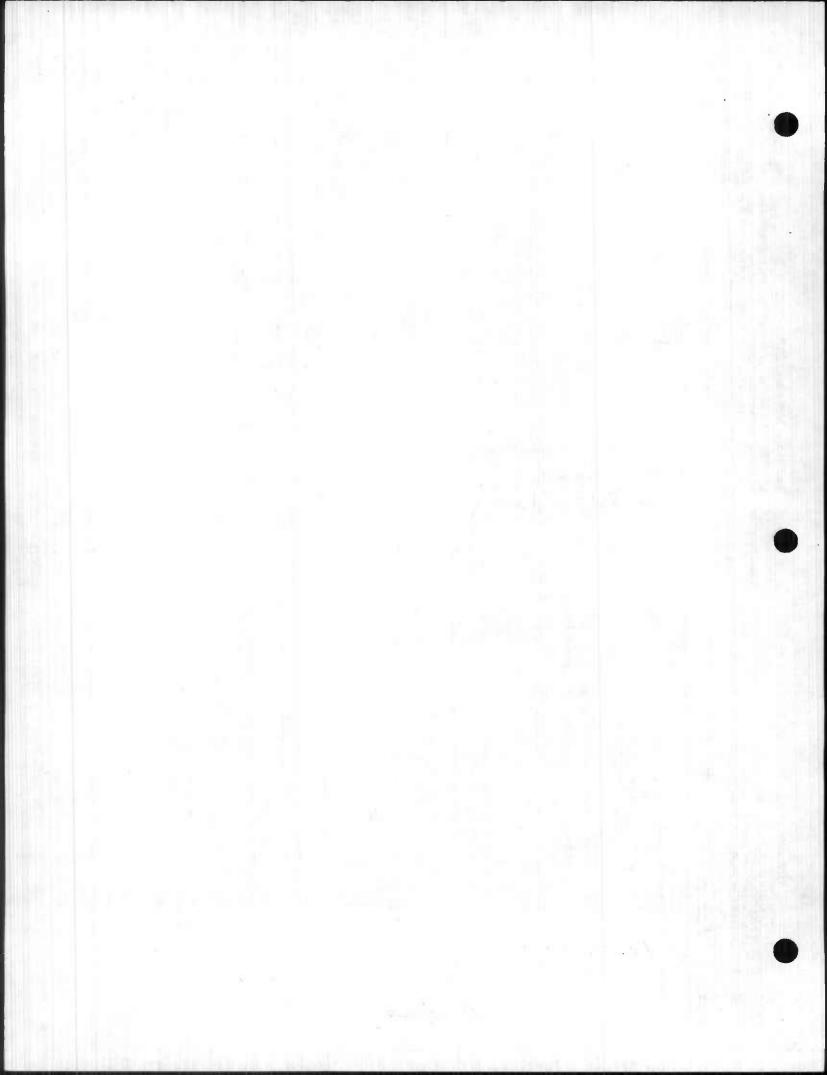
29c. License number

H0055108

29d. Data signed (Month, Day, Year)

21201

2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death George Leo Lawler, Sr. APR14 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore ff Under 1 Yaar | If Under 24 Hrs. | 5. Social Security Number 8. Data of Birth (Month, Day, Year) 09/30/1917 Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 10 M 2□ F Months Days Hours Yrs. 82 213-01-9812 MD. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 250No MD. Baltimore Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 444 Chalfonte Dr. 21228 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. White 1 MYas 2 □ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 25% Married 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Project Administrator Westinghouse 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) William F. Lawler Rose B. Thomas 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Louise Elise Lawler 444 Chalfonte Dr. Baltimore, MD. 21228 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burlal 2 □ Cramation 3 □ Ramoval from Stata Crestlawn Cemetery 04/10 4 ☐ Donation 5 ☐ Other (Specify) Marriotsville, MD. 21. Signatura of Funaral Service Licensaa Sterling Ashton Schwab Funeral Home, Inc. 5 Veuden 736 Edmondson Ave. Baltimore, Md. 21228 23a. Part1. Enter the disease for complications that ceusad the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death recommentes fmmediate Cause (Finel 10 montes disaasa or condition rasulting in daath) years COPD Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Diseese or injury that initieted evants resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? mertensive artenosclerate cardinassular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown replrosclerosis. 24b. Were eutopsy findings available prior to 24a. Was an eutopsy performed? completion of ceuse of death? 1 Nas 2 □ No 1 Vas 2 No 25. Was cese rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 DInpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 DNatural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 4 Homicida

2 0 or Attending Division deeth. W

Physician/Medical þ Completed Be Medicai Certification: To

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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altimore, Maryland 21215-0020

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permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked or any injury or other traumatic eva

**Physician** 

/Medical

Examiner

24 hours after deel Funeral Director: within 2 \$

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifiar

29a. Certifier (Check only one)

30. Nama and address of person who complated ceusa of death (Itam 23a) (Type, Print) STAGNES HEALTH CARE
WILLIAM I HICKEN, MD GDO LATON SIK MALTIMANE 32. Registrar's Signatura

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I Dicken In i).

900 CATON AVE BALTIMORE, MAZIZZA

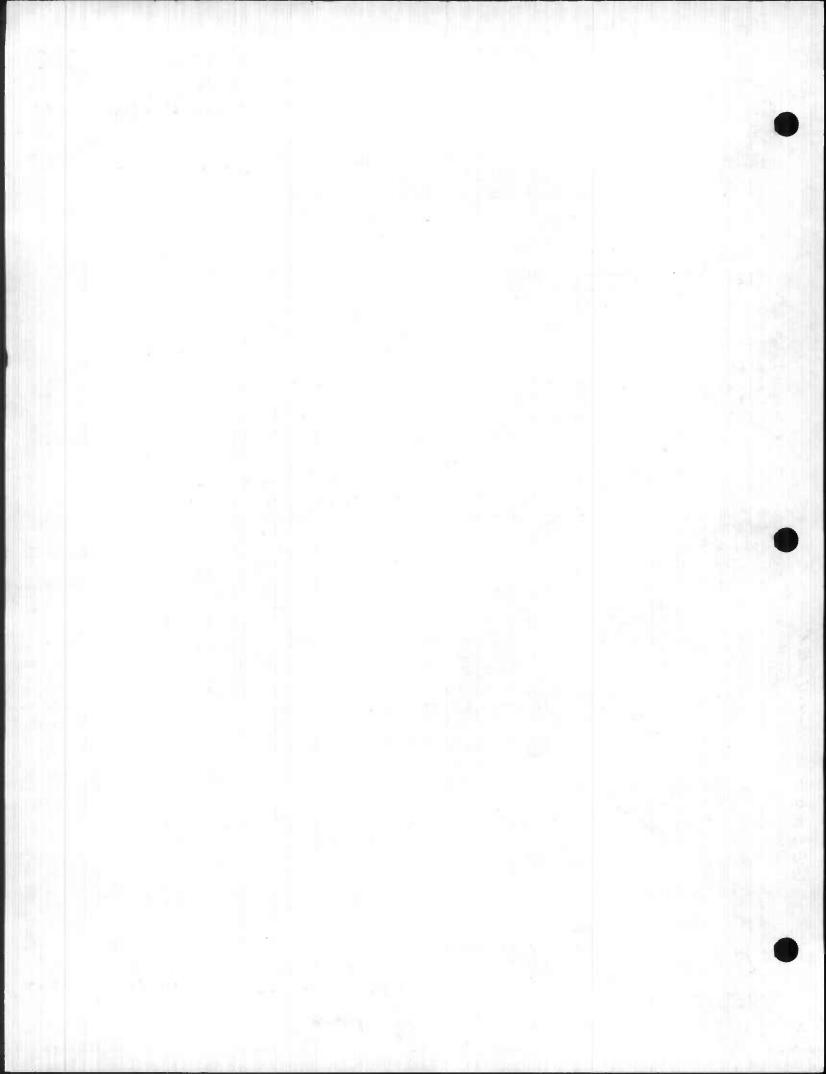
1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

DO4964

29d. Data signed (Month, Day, Year)

**ORIGINAL** 



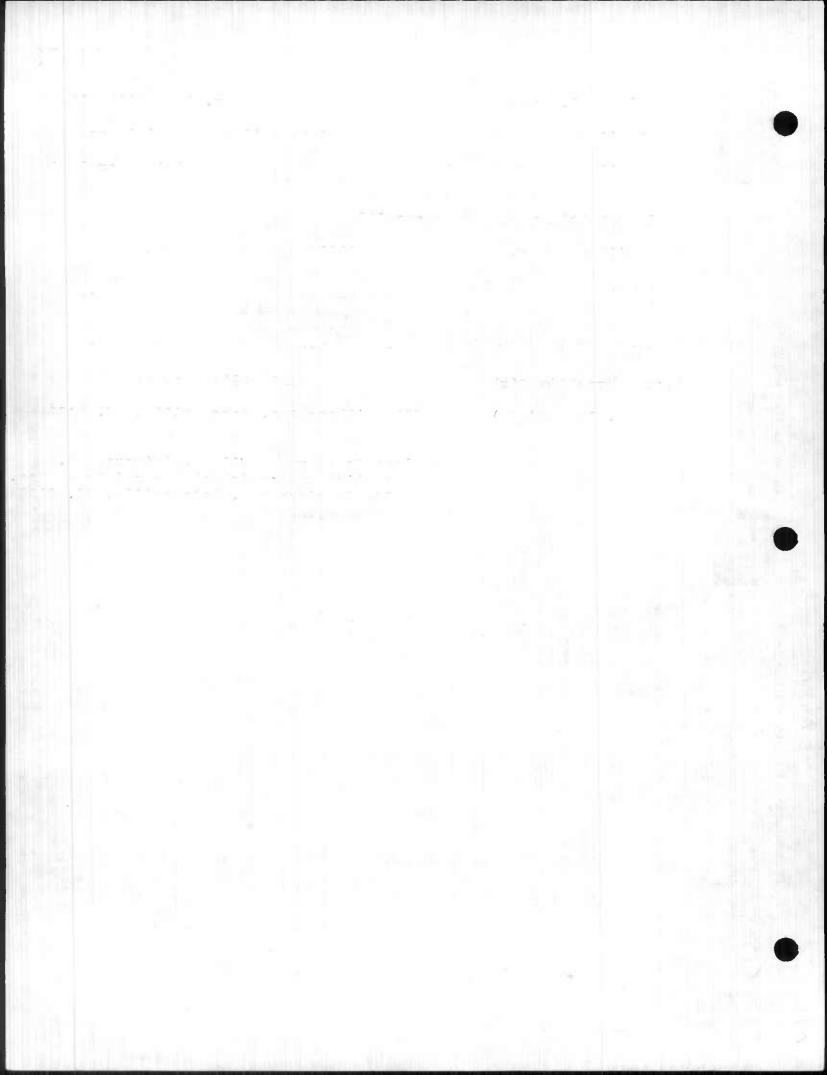
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State of Maryland / Department of Health and Mental Hygiene

11673

			Ce	rtificate of	Death		Re	g. No.	U	11073
Physician	1. Decedent's Neme (First, Middle, Las Elton L.	Lanman					Date of Death	1	0.000	3. Tima of Death 11:40 AM
/Medical Examiner	As Fastin Name (Mass institution - in	e street and number)				vn, or Locatio	n of Death	4c. County		e
Funeral Director	5. Social Security Number 6. S 2 2 0 - 0 3 - 0 1 1 6	ex 7. Age (In y	rs. last birthday) 2 Yrs.	If Under 1 Yee Months Days		Min. 8. D	Date of Birth Month, Day, LY	Y917917	9. Birthple	lace (State or Foreign
Maryland H show	Usual Residence of Decedent 10a. State 10b. County  Maryland Baltim		City, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
Office death with the Mar r ferme 23s or 28s-f si rice ment be notified. Funeral Director	10e. Street and Number 5612 Wilkens A			10f. Zip Code 2 1 2	28		10	Og. Citizen of V USA	Vhat Count	ry?
urs a view by	3 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates:		Was Decedent of If Yes, specify Cul	oan, Mexican	in? (Specify Puerto Ricar	Yes or No- n, etc.)		e - America ck, White, e	
72 hours "natural",	15. Decedent's Ed	ucetion de completed)	16a. Dece	dent's Usual Occu	pation during most	of working	1	6b. Kind of Bu	siness/Ind	ustry
od within 72 ho yglana. wr than "naturi ft, the Weden!	Elementery/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retin	ker			Own	ноп	ne
and 2 be filed that Hygi d other event, the	17. Father's Name (First, Middle, Last)	n Kirby			18. Mothe	,		faiden Sumam Sawye 1		
C 40 E E	t9a. Informant's Name/Relationship (1) Barry A. Lanma	Type, Print)	19b. Maiti 561	ng Address (Stree 2 Wilke	and Number	r or Rural Ro	ute Number, at on s	City or Town, Ville	State, Zip	Code) 21228
Baltimore, N permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.	20a. Method of Disposition  DEBuriel 2 Cremation 3   4 Donalion 5 Other (Specify  21. Signature of Funerel Service Licen	Removel from Stete	Stable		tery	4/1 ton-Sc	ll chwab		nore,	
box 50700, both contributions of a standing physician and a standing physician and a standing physician and a standing physician and a standing clan/Medical Examiner	Cause (Diseese or injury that Initiated events resulting In death) Last	· Congosti	for as a consection of the second of the sec	ent so	lire					Onset and Death Typ  Year  Je
for for	Part It. Other significant conditions co	ntributing to death but not r	esulting In the u	nderiving cause o	iven in Part I	1	23h Did to	hacco usa cor	ntributa to	the cause of death?
Dry th			oodking in the	ridonying duddo g			1 🗆 Ye		,	nebly 4 Unknown
s been s 2 should						_	24a. Was ar perform		ava	ore autopsy findings allable prior to mpletion of ceuse death?
= - 50 0							1 ☐ Ye		1 🗆	Yes 2 No
Physician: The Physician: The Idirector, part of the Control of th	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA	hor	of Death (Ch		nce 6 Oth	or (Specific	4)
Low Attending Physical death.  Director: After this din by the funeral diffication: To ertification: To		28a. Dete of tnjury (Month, Day Year)		28c. tnje		28d.		w injury occurr		,
LIVISION C ball or Attending P is after death. al Director: After t ed in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spe	- At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number						Route Number,	
To the Hospital or A within 24 hours after To the Funeral Bire completely filled in b		vaician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	n occurred at the t vestigation, in my	ime, dete end opinion, deet	plece, end d h occurred at	the time, da	use(s) end me ite and place, i	nner as sta and due to	ated. the ceuse(s)
To the comp		10		29c. Licen	se number	2	25	Date signed	d (Month, C	Day, Year)
	30. Name and address of person who of	completed cause of death (III	tem 23a) (Type,	Priori) 102	E	in con	T Cut	y M.	020	1043
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature &	Spou	6					

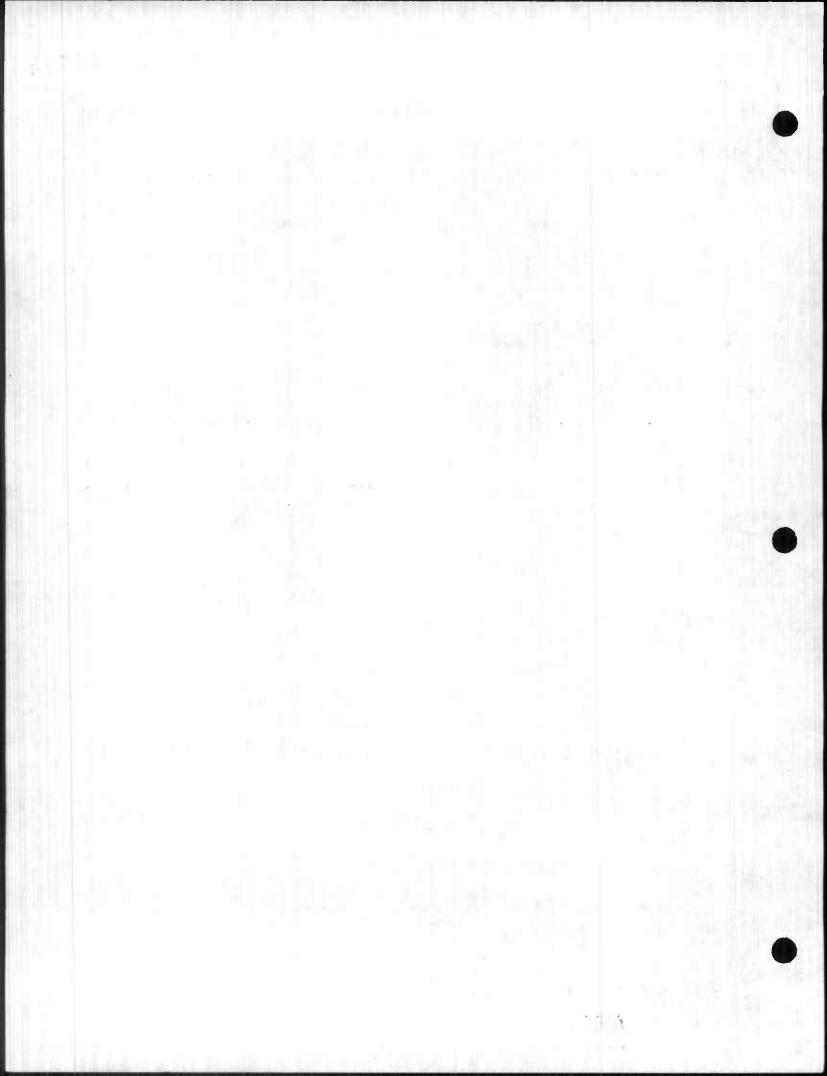
DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate	e of Death	,	g. No.	10 116/4
Physician	1. Decedent's Name (First, Middle, La	J. Lav	hain		2. Dete of Death	Day	Year 504
/Medical	4e Facility Neme (If not institution, giv		Marin	4b. City, Town, or	Location of Death	4c. County	of Death
Examiner	Howard County (		a 1	Columbi			rd County
Funeral	5. Social Security Number 6. S		last birthday) If Under	1 Yeer   If Under 24 Hrs			Birthplece (State or Foreign Country)
Director	220-12-8937 Usual Residence of Decedent	□M 20 F 90	Yrs. Months	Days Hours Min	8. Date of Birth (Month, Day, July 31	,1909	Maryland
yland	10a. State 10b. County	10c. Cit	y, Town or Location				10d. inside City Limits
uth with the Manylan 23a or 28a-f show unt be notified at	Maryland How	vard		Columb	oia		1 ☐ Yes 2 1 No
vith the Ma t or 28a-f s be nother	10e. Street end Number		10f. Zip	Code	10	Og. Citizen of W	/het Country?
23a 23a	6150 Foreland Ga	rth		21045			d States
72-002.0 72 hours after death with the Manyland "natural", or flema 23a or 28a-f show deat Essentine must be nothed at	11. Meritel Status  1 Never Married 2 Married  32 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2\2\3\no If Yes, Give Year or Dates:	S. 13. Was Deced If Yes, spec	ent of Hispanic Origin? (sify Cuben, Mexican, Puered No Specify:	Specify Yes or No- to Rican, etc.)		a - Americen Indian, k, White, etc. . White
ed within 72 hours at yogiena.  writian "natural", or fir in Medelem for the Completed by §	15. Decedent's Ed		16e. Decedent's Usua	Occupation	odvine.	16b. Kind of Bu	siness/industry
	(Specify only highest gra Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT us	k done during most of wo e retired)	irking		
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should be filed within and Mental Hygiena. marked other than unatic event, the Manual To Be Comp	William Wills  19a. Informent's Name/Relationship (	Daughte	r/		nerine Le		
2 4 4 4	Mrs. Shirley M.	Strange	11710	Wayneridge (			
permit. Pages 1 and Department of Health important: If flew 27 any injury or other then 266.	20a. Method of Disposition  1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specification)	Removel from State	Place of Disposition (Name remetery, cremetory or of rdens of Fa	ne of her place) ith Cemetery			City or Town, State SVille, MD
permit. Pag Department Important: I eny Injury o	21. Signature of Funerel Service Licer		22. Name en	Address of Fecility Ruck Funeral	Tioms of	Dan de l	le Two
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Physician	snock, or heart tarryre. List only	ene cause on each line.		1	0 1		Onset and Death
/Medical	Immediate Cause (Final disease or condition	cong	estive	heart t	allin	2	lucek
Examiner	resulting In death)	a. Due to (c	or es a consequence of):	heart f	0010001	/.	1.000
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ficate be executed physician and is the burial-transit	Sequentially list conditions,	Due to (c	r as a consequence of):		1		
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that the death cert ed by the attanding detached for use a	Pert II. Other algnificant conditions of	ontributing to deeth but not res	uiting in the underlying co	euse given in Pert I.	230. Did to	- /	atributs to the causs of death?  3 Probably 4 Unknown
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sician: The law requiras to certificate has been signe lirector, paga 2 should be to Be Completed by					1 🗆 Ye	s 2 No	1 ☐ Yes 2 € No
certificate har inector, paga	25. Was cese referred to medicet examiner?	-		26. Place of De	ath (Check only on	6)	
2 00	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ DO	A Other: 4 Nursing	Home 5 Reside	nce 6 Oth	er (Specify)
ng Phys fler this neral di	27. Mapher of Death  1. Neturel 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 29	Bc. Injury et Work?	28d. Describe ho	w injury occurr	ed
Attending or death.  ctor: After by the fune lification	Accident investigation		М	1 ☐ Yes 2 ☐ No			
tal or Attending P rs effer death. al Director: Affert led in by the funers Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street, factory	, office	28f. Location (St City or Town		er or Rural Route Number,
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To the within To the comp	29b. Signature and title of certifier	10,00	290	License number	2	9d. Date signed	(Month, Day, Year)
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ENRIET 2.45 AM EWIS UCILLE APRIL 09 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP AGNES BALTIMORE IN Under 24 Hrs. 8. Date ITAL If Under 1 Year 8. Date of Birth (Month, Day, Year) DEC. 13,1914 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 2 KF 75 Yrs. 212-28-1400 NORTHU Director AROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f ahow Examiner must be notified at Yes 2 No Director MARYLAND ALTI 10e. Street and Number 10f. Zip Code Og. Citizen of What Country? AR 1216 USA. Funeral GROVE Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: 3 ₩Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 3 RD GRADE College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Mentel hygien important: If them 27 te marked other that any fulury or other traumatic event, if a place. 41DE NURSING 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 TENRI NORMAN TOVAL 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Flural Route Number, City or Town, Stete, Zip Code) 2004 UCILLE JOHNSON (DAUGHTER HOPLAR GROVE SI BALTO, MD, 21216 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERIOY-15-00 LAUREL. 22. Nama and Address of Facility BRO JOSEPH H. BRO 2140 N. FULTON 21. Signature of Funeral Service Licenses JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory afrest, shock, or heart failure. List only one cause on each line. 212 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical GASTROINTESTINAL BLEEDING Examiner Examiner RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): and Physician/Medical Dua to (or as a consequence of): Z Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed to should be det p Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ō 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Naturai 5 Pending 1 Yes 2 No deeth. investigation 2 Accident 24 hours after dee Funeral Director: 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -ADDO 2502 W 32. Registrar's Signature 31. Data filed (Month, Day, Year) State Registrar sparks

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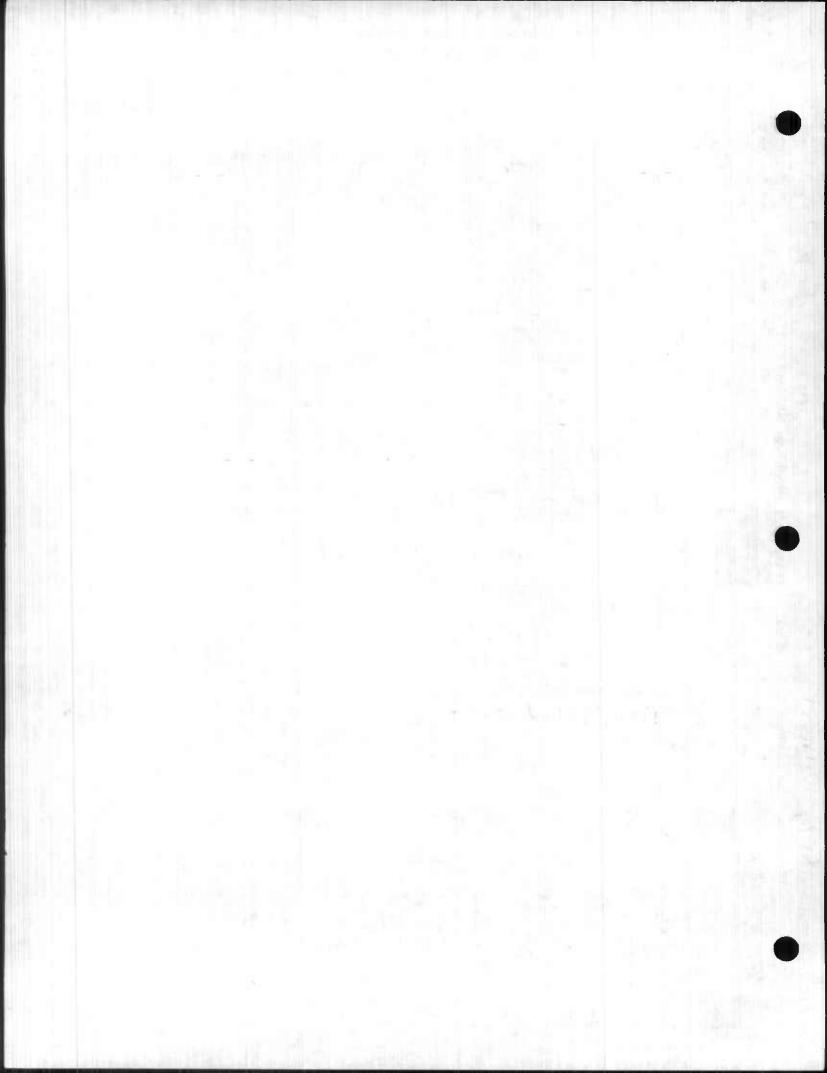
State of Maryland / Department of Health and Mental Hygiene

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an cal		Wilbert	F. La	tney.	Jr			A	PRIL	9 2	000	8:4	2 AM
er 4a Facility Name (If r	not institution, giv					4b	. City, To	wn, or Loca	tion of Death	4c. County	of Death		
St Agnes	Hospit	al						more		N/A			
5. Social Security Nur		69x 7. A	ge (In yrs. la		If Under Months	1 Year Days	If Under :	24 Hrs. 8 Min.	. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (Sta	te or Foreig
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	200												es 2 N
Md	Balti	more	Ranc	lallst									*
Md 10e. Street and Numb					10f. Zip	Code			11	0g. Citizen of	What Coun	iry?	
3514 Cabot	t Road					1133				USA			
11. Marital Status	V V	12. Was Decedent Armed Forces	?	. 13. \	Vas Decede Yes, speci	ent of His ify Cuban	panic Original (Control of the Control of the Contr	gin? (Speci i, Puarto Ri	ty Yas or No- can, etc.)		ck, White,		
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	15. Decedent's Ed			16a. Deced	ent's Usual	Occupat	tion	of working		16b. Kind of B	usiness/Ind	ustry	
Elamantary/Second	y only highast gra dary (0-12)	Collega (1-4or	5+)	life. L	O NOT use	e retired)	iring most	t of working		Kennec	ott Re	efin	ing C
12th gra	ide	2 years		Sup	ervis	or							
(Specify Elementary/Second 12th gra 17. Father's Name (F	irst, Middle, Last,	)				= 4	18. Mothe	r's Name (	First, Middle, A	Maidan Sumar	na)		
Wilbert	Latney,	Sr					Sara	Lee					
19a. Informant's Nan	ne/Relationship (	Type, Print)		19b. Mailin	g Addrass	(Street as	nd Numbe	or or Rural I	Routa Number	City or Town	, Stata, Zip	Code)	
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Immediate Cause (Fi	inal	m	11.	10	Ma	1					i	lass	
disease or condition resulting in death)		· Mu				101	om	1 a			1	Teo	7
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Lather Wilbert

DHMH 16 Ray 6/95

ORIGINAL



**DHMH 16 Ray 6/95** 

State

Registrar

APR 1 1 2000

32. Registrar's Signature

SERVICE SECULAR SOURCE

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note to people to A was the form of

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dev Year **Physician** 6, 2000 4c. County of Death Virginia A. Miller April 5:00 PM /Medical 4s Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 5500 Todd Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F 218-16-1943 23, Director Nov. 1922 Maryland Usual Residence of Deceden the Manyland 10a. State 10b. County 10c. City, Town or Location Ahow 10d. Inside City Limits "natural", or items 23s or 28s-f show XX Yes 2 No N/A Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with all Hygiena. other than "natural", or flema 23a or vant, ma Mad all Escopes mad be I 5500 Todd Avenue 21206 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 ☐ Yes 2 ₩ No 1 Never Married 27 Married Baltlmore, Maryland 21215-0020 1 Yes √2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home L. Peges 1 and 2 should be filed vitnent of Haelth and Mental Hygie ant: If item 27 is marked other to larry or other treumstic avant, in 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 80 Edward Turner E. Cavanaugh Mary 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Miller Son 35 Heather Road Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, Stete 1 Purial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) permit. Pege Department of Important: If any Injury or page. Dulaney Valley Memorial 4/10/2000 Cockeysville, MD 21. Signature of Juneral Service Lice Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Denly . Do not enter the mode of dying, such as cardiac or respiretory errest, Intervel Between Onset and Deeth Physician /Medical tmmediate Cause (Final Small cell IYEAR disease or condition resulting in death) Examiner Due to (or as a consequence of): buriel-transit or Attending Physician: The law requires that the deeth certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the buriel Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Tea 2 No 3 Probably 4 Unknown EMPHYSEMA Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 cartificeta 1 Yes 1 Yes 2 No director 8 25. Was case referred to medice! 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 100 funanti 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Affer 1 Q(Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation efter dasti Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours Funeral C 107 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 \$

State Registrar **DHMH 16 Rev 6/95** 

29b. Signatura and title of certifier

**ORIGINAL** 

aclain MD

32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lospital drive, suite 206

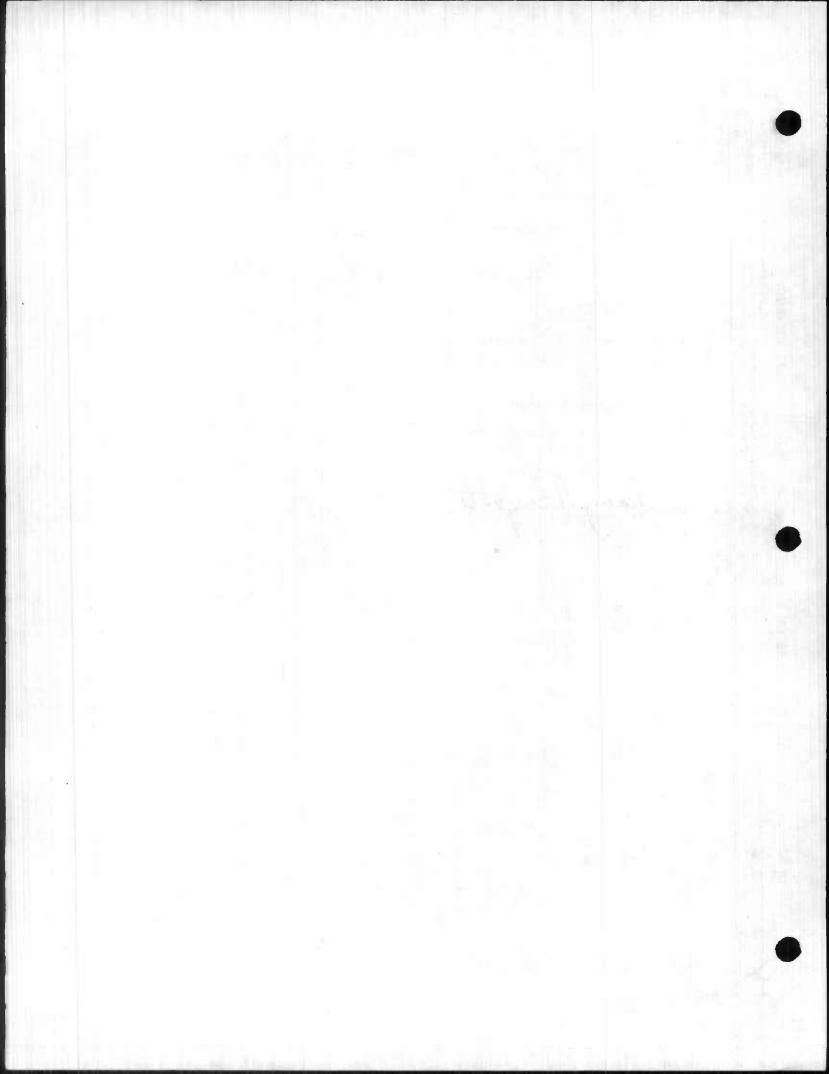
29c. License number

parks

Baltimore

29d. Date signed (Month, Day, Year)

mo-21237



Registrar

State

31. Dete filed (Month, Day, Year)

APR 1 1 2000

Darks

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Year William R. Miles APRIL 9. 2000 12:55PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Sex 5. Social Security Number Months Days 1 M 2□F Yrs 579-50-1235 82 Apr 18, 1917 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1016 Southridge Road 21228 USA 12. Wes Decedent Ever in U,S. Amed Forces? 1 Sives 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Merital Status 1 Never Married 252 Merried 1□ Yes 2XNo lf Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administration Worker Government/ NSA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) William H. Miles Mammie Effie Swann 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Miles/ wife 1016 Southridge Road, Catonsville, MD 21228 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Loudon Park 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 04/12/00 Balto. MD 4 □ Donation 5 Dother (Specify) entombmen Sterling-Ashton-Schwab Funeral Home, Inc. 21. Signeture of Funeral Service Lip 736 Edmondson Avenue Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediete Cause (Finel disease or condition resulting in death) RESPIRATORY INSUFFICIENCY WEEK Due to (or as a consequence of) PULMONARY EMBOLI DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): INTRATHORACIC BLEEDING DAYS that initieted events resulting in death) Lest Due to (or es a consequence of) CORONARY ARTERY BYPASS ANTICOAGULATION 13 DAYS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 | No 3 | Probably 4 | Unknown ARTHEROSCLEROTIC HEART DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2 No 1 Yes 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2% Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

2 Completed

Physician/Medical Examiner use as the burial-transit and Por signed by t page 2 this certificate has Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

then "natural", or items 23s or the Medical Exeminer must be n

filed within 72 hours after

Hygiana.

permit. Pages 1 and 2 should be file.
Department of Health and Membal Hyg.
Important: If them 27 is marked
any injury or other

**Physician** 

/Medical

Examiner

Box 68760.

P.0.

of Vital Records.

Division

Maryland 21215-0020

Directo

Funeral

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Completed

The law requires that the death certificate be executed tal or Attending Physician: T is after death. at Director: After this certificat led in by the funeral director, p. filled In

To the Hospital within 24 hours a To the Funeral C completely

State Registrar

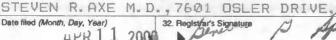
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

31. Date filed (Month, Day, Year) APR 11

offing to other the

29a. Certifie



TOWSON, MARYLAND 21204 Sporks

189. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

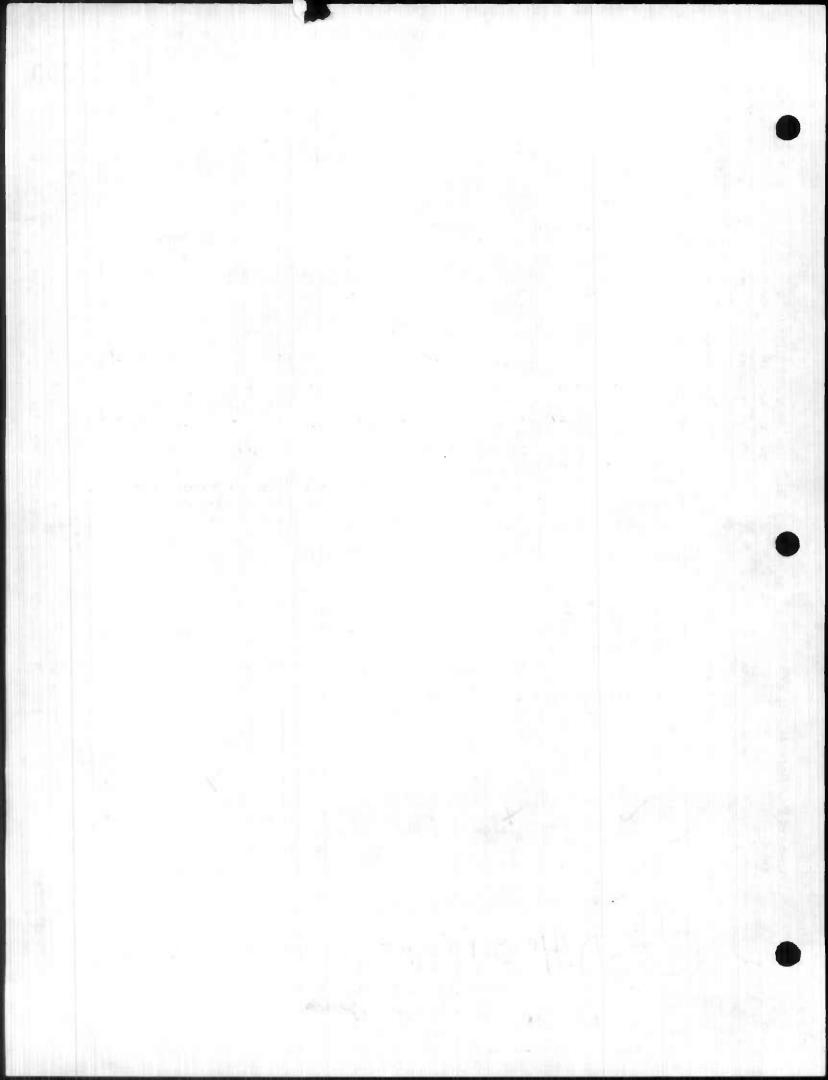
29c. License number

D34543

29d. Date signed (Month, Day, Year)

-10-00

10009



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Mickele, Last) 2. Date of Death Month Day Year Tuch 2000 4a Facility Name (If not insulation, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manyana Universe Ly 0. 5. Social Security Number 216-55-981 rection more STEMS 7. Age (In yrs. linst birthday) If Under 1 Year Birthplace (State or Foreign Country) 6 Ser 8. Date of Birth (Month, Day, Days Hours 1 M 2 XF Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? USA, Race - American Indian, STREE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1□ Yes 20 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) KENNETH RICHARDS MADDOX VERA 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARDS (MOTHER) 508 N. CAREY ST., BALTIMORE, MD. 21223 In (Name of Date 20c. Location - City or Town, State YERA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremetion 3 Removal from State ZION (BABYLAND) 22. Name and Address of Facility JOSEPH 2140 N. FUL 5 Other (Specify) -05-00 LANSDOWNE, MD. re of Funeral Service Life BROWN JR. FUNERAL HOME FULTON AVE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): entially list condition leading to immedia Enter Underlying (Disease or injury Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 2 DER/Outpatient 3 DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify)

Physician/Medical Examiner Box 68760. 9 The law requires that the death Records, P.O. à B Completed certificate of Vital Attending Physician: 88 Certification: To # After Division To the Hospital or Attent Within 24 hours after deat To the Funeral Director:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

7 is marked other traumatic event, to

Department of Important: If any Injury or page.

Physician /Medical

Examiner

. Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked off jury or other traumatic even

Director

Funeral

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Be Completed

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the Maryland

filed within 72 hours after death with

21215-0020

Baltimore, Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 Yen 2 No 27. Mannes of Death 28d. Describe how injury occurred 28b. Tene of 28c. Injury at Work? t Natural 5 ☐ Pending 1□Yes 2□No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and my my stated. 29a. Certifier (Check only one) 29b. Signature and title of attritio 29c. License number 29d. Date signed (Month, Day, Year)

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Greene

Street

South

BAltimore, Maryland

State Registrar

Medical

APR 11 2000 **DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

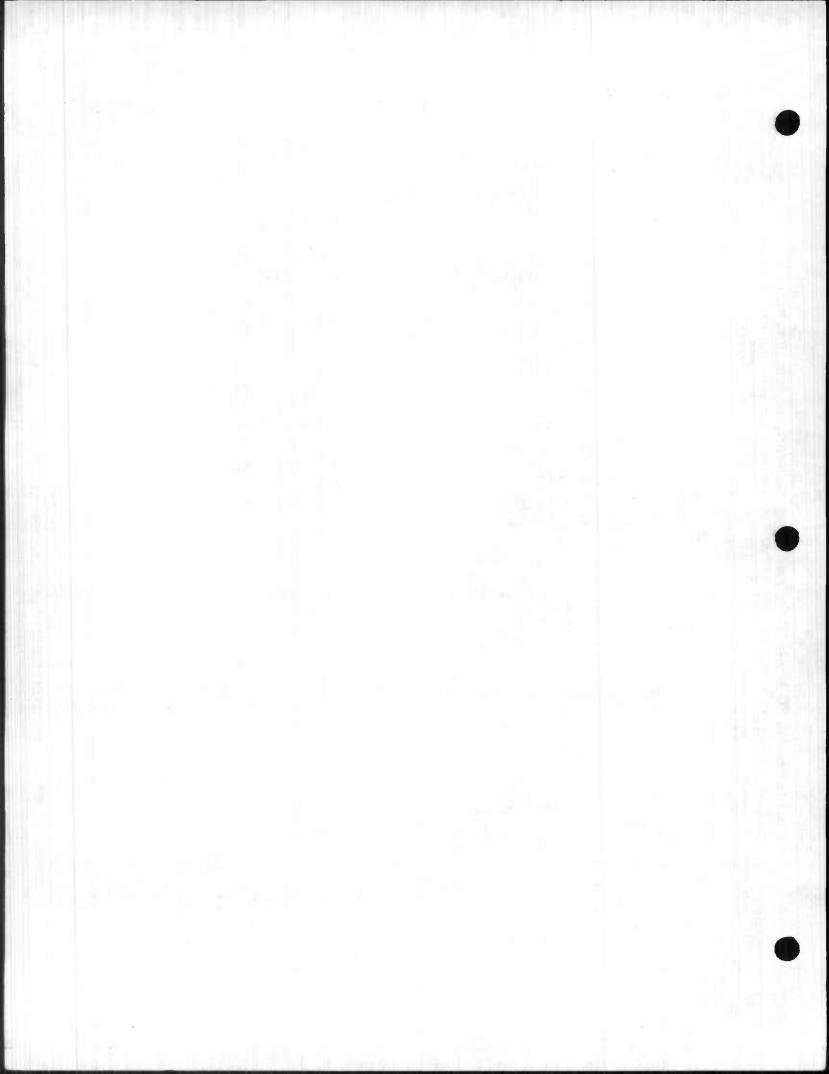
Kobert

Englander

University of Maryland

od cause of death (flem 23a) (Type, Print)

32. Registrar's Signature

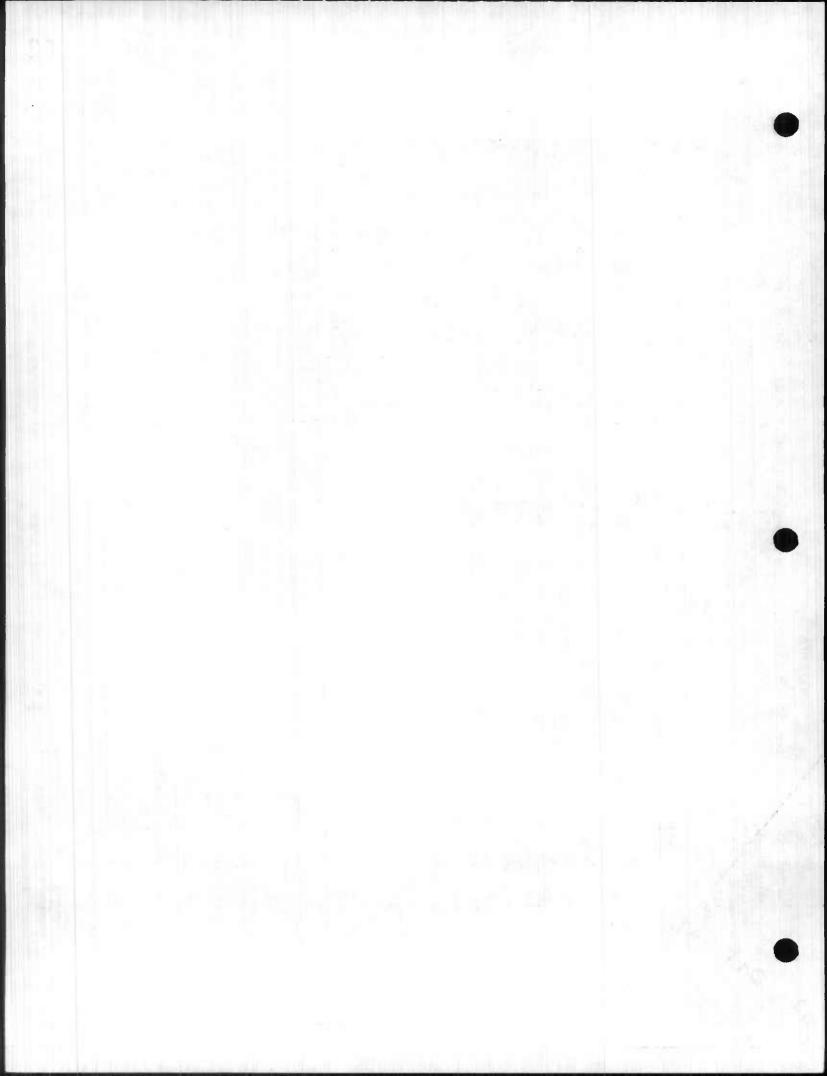


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			Otato of Marylar		tificate of			eg. No.		11002	
	Physician	1. Decedent's Neme (First, Middle, Last	Decedent's Neme (First, Middle, Last)				2. Date of Dee Month	th Dey	Dev Year		
15-0020 72 hours after death with the Maryland Office Pratural, or Name 23a or 28ed show of the State of the State of the State of State o	/Medical		William H.	Murray			April	8	2000	8:30 A.M.	
	Examiner	4a Facility Name (II not institution, give				4b. City, Town, or L		4c. County			
		Millennium Heal			Cen.	Glen Bur		del			
	Funeral Director	5. Social Security Number 6. Se 214 18 3012	x 7. Age (In yrs. 78	Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey April 6	, 1922		ce (State or Foreign y) yland	
	ð u	10a. Stete 10b. County	10c. Ci	ly, Town or Loc	ation				100	d. Inside City Limits	
	0	Maryland Anne Ar	rundel Ba	ltimore	2					1 ☐ Yes 2 No	
	r tems 23s or 28s-f s obserment be notified Funeral Director	10e. Street and Number 1348 Hollow Glen	10f. Zip Code 21226				0g. Citizen of V U.S		y?		
	al', or hams Empherm by Funer	11. Meritel Stetus  1 Never Merried 2 Merried 3 Widowed 4 M Divorced	12. Wes Decedent Ever in U Armed Forces? 1∑ Yes 2 □ No If Yes, Give Yeer or Detes:W • W •		Ves Decedent of H Yes, specify Cub	dispanic Origin? (Si en, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rec Bled Specify	a - Americar k, White, et Whi	c.	
	ygiene. To then "natural", of It, the Madeel Emit Completed by	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give k	O NOT use retire	during most of world)	king	16b. Kind of Bu		stry	
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aryla	end Menis s marke sumatics	19e. Informent's Neme/Reletionship (T)	-	19b. Meiling	Address (Street	end Number or Ru			State. Zip C	Code)	
	27 le r trau	Teresa Bollinger	/ Niece			len Cour				and 21226	
re,	Health itsm 27 other tr	20a. Method of Disposition	20b. I		ition (Neme of etory or other ple			20c. Location -			
mor	it it i	1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temovel from Stete				1/11/00	Crownsv:	ille,	Maryland	
Baltimore,		4 Donation 5 Other (Specify)  Md. State Veteran Cem. 4/11/00 Crownsville, Marylan  21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  Gonce Funeral Home P.A.  4001 Ritchie Highway Baltimore, Md. 21225									
		23a. Part1. Enter the disease, or compl shock, or heert feilure. List only or	icetions thet caused the deat						: /	Approximate nterval Between	
Exar	/Medical xaminer	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (c	Due to (or as a consequence of):  Due to (or es e consequenca of):  Due to (or as a consequenca of):							
X 6	attending   for use es		d						i		
Box	on in for u		Part II. Other significant conditions contributing to death but not resulting in the underlying ca				1 001 0111	Did tobacco use contribute to the cause of death?			
P.O.	igned by the attending be detached for use by Physician/M							☐ Yes 2☐ No 3☐/Probably 4☐ Unknown			
S, F	signed of be del	- PEME				7					
Records, P.O. Box	ata has been signage 2 should to Completed						24a, Wes e perform	en eutopsy med?	com	e autopsy findings lable prior to pletion of cause eath?	
R E	age 2 omp						1 🗆 Y	es 20(No	10	Yes 2□ No	
		25. Wes case referred to medical				26. Plece of Dee	oth (Check only or				
† V	this certain direction.	examiner?	fospitel: 1 Inpatient 2 I	ER/Outpatient	3 DOA Oth	200: 4	ome 5 Reside		er (Specify)		
Division of Vital Records, To the Hospital or Attanding Physician: The law requires the	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	27. Menner of Death  1 Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)  28b. Time of Sec. Injury et Work?  Injury  M  1   Yes 2   No				28d. Describe how injury occurred				
	at Director: After the in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At home, farm, street, factory, office building, efc. (Specify)			281. Location (Street and Number or Rural Route Number, City or Town, Stele)					
Ne Hospi	within 24 hours To the Funeral completely filled Medical C	29e. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated.  Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated.  Check only one)									
Tot	To the Com	9b. Signeture and title of certifier 29c. License number					29d. Date signed (Mo				
	11	1. Luc	H.J.		)	22609	BRANCH. Rd GLENBURNIE MORRIE				
	State	30. Name and address of person who con RUBEN AE 1 31. Dete filed (Month, Day, Year)	mpleted cause of deeth (Item  DER M.D.  32. Registrer's Signe	7445	FURA	JACE B	RANCH.	Pd 60	ENBL	PRNE HOLICE	
	State Registrar	APR 1 1 2000	Senera	4	lan 1						

DHMH 16 Rev 6/95



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11683 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yaai : 45PM Bezold Osterling Apri 2000 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Bal timore Hospita MOVR If Under 24 Hrs. Birthplace (State or Foraign Country) d. Sax 8. Data of Birth (Month, Day, Age (in yrs. last birthday) Months Days Hours 1□M 20 F Countr MD • 58 Usuel Rasidenca of Dacedant 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Baltimore Owings Mills 10f. Zip Coda 10g. Citizen of What Country? **USA** 19 Church RD. 21117 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Reca - American Indien, Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamentary/Sacondary (0-12) Collega (1-4or 5+) Teacher Day Care School 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) A. Bezold Virginia E. Haywood 19a. informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) Walter J. Osterling 19 Church Rd. Owings Mills, MD. 21117 20b. Place of Disposition (Nama of cematary, cramatory or other placa)
Lorraine Park Cemetery 20c. Location - City or Town, Steta 1 ■ Burlel 2 Cramation 3 Ramoval from Stata 04/12 Woodlawn, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Enterel Servica Licensea 22. Nama and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. J. Wayne Osterling 736 Edmondson Ave. Baltimor wass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, faults. List only one couse on each line. 736 Edmomdson Ave. Baltimorem Md. 21228 Approximata Intarval Batween Onset and Death as a consequence of) Dua to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yee 2 ☐ No 24b. Wara autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No al No 25. Was casa rafarred to medicaf axaminer? 28. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 8 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Yas 2 No 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Madical Examiner: On the basis of commination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore, **Physician** /Medical Division of Vital Records, P.O. Box 68760.

Examiner The law requires that the deeth certificete be executed the burial-trar certificate hes Attending Physician: ours after deeth.

neral Director: After this
filled in by the funeral di this ò To the Hospital or within 24 hours at To the Funeral D completely filled it

Physician/Medical

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Completed

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Certification:

Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Hygiene.

Pages 1 and 2 should be nent of Health and Mental

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event, the Medical Examiner

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10e. State

5. Sociel Sacurity Number

10e, Street and Number

12

20a. Mathod of Disposition

immediata Causa (Final diseasa or condition rasulting in death)

Sequentielly list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last

axaminer/ 1 ☐ Yas 2 No

27. Mannar of Death

1 Natural

2 Accident

3 Suicida

29a. Certifiar

4 Homicide

(Check only one) 29b. Signature a

nd title of certifier

11. Maritel Status

John

213-40-1928

Registrar

nona - Ha 31. Data filed (Month, Day, Year) APR 11

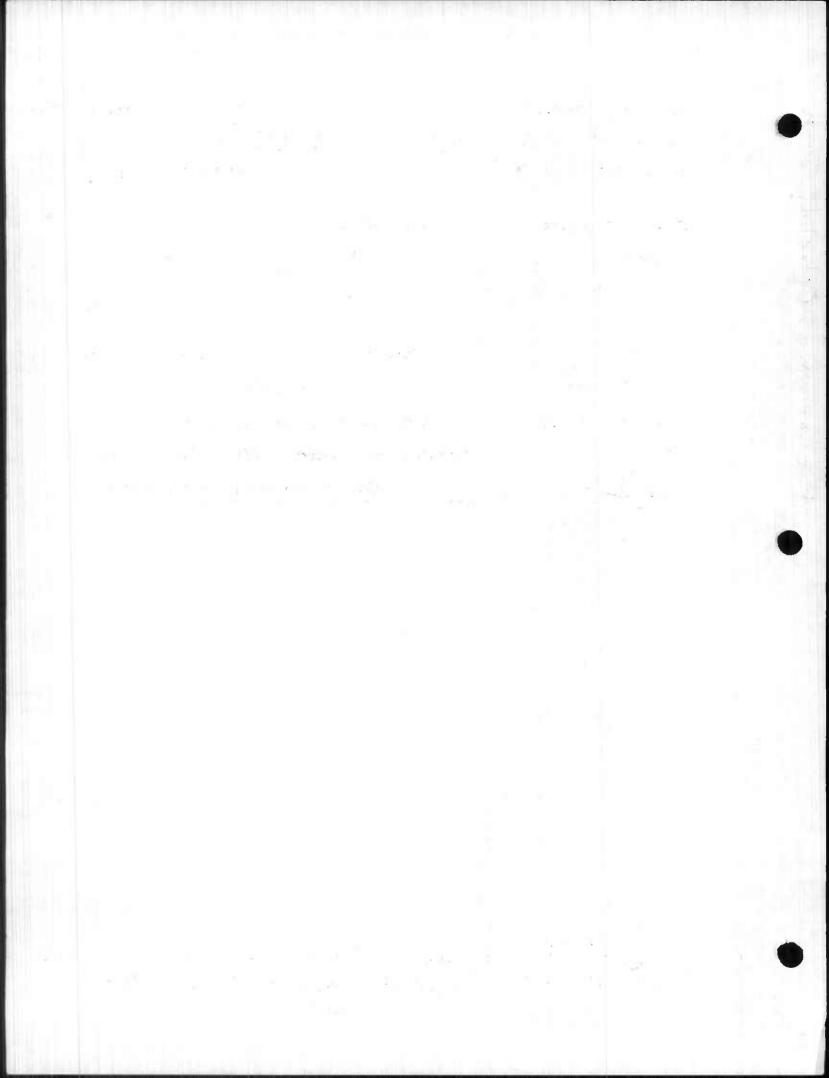
Name and andress of person who complete 2401

benev

d ausa of death (Rem 23a) (Type, Print) W. Belvedere Ave, Baltimore, MD Z1215 32. Registrar's Signetura

29c. License number

29d. Date signed (Month, Day, Year)



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 684 Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month 5:54 AM STEPHEN OICKLE Apri 2000 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Burnie Norgh Jospita S 16V 1 Arunde Sex XXM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplece (Stete or Foreign Months Days Hours 46 MARYLAND 214-66-1151 1953 Usual Residence of Decedent 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 MARTHA ROAD 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Detes: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 OWNER/OPERATOR MARBLE/ART 17. Father's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) MELBURNE OICKLE EILEEN MCATEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) EILEEN MARIE OICKLE (MOTHER) 119 MARTHA ROAD, GLEN BURNIE, MD. 21061 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stale 20e Method of Disposition APRIL 10 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEMORIAL PARK 2000 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD. 22. Name and Address of Facility 21. Signature of Furieral Service Licensee SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 MOD 264 Magan 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. 4 days Immediate Cause (Final disease or condition resulting in death) Theumonia At alectasis with mucous plugging Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lesi Amyotropic Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ∏ Yes 2 ∏ No 25. Was case referred to medical 26. Piace of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Deeth 28d. Describe how injury occurred Injury at Work? 1 Neturel 5 Pending investigation

Physician /Medical Examiner

Pages 1 and 2

Department of Health important: If Nem 27

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23s or 28s-1 show

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Physician/Medical Examiner Be Completed by

this certificate has Medical Certification: To

The law requires that the death certificate be executed Box 68760, P.0. of Vital Records, or Attending Physician: Director: After this certific d in by the funeral director, Division filled in by To the Hospital within 24 hours a To the Funeral C

DHMH 16 Rev 6/95

State Registrar 29b. Signature end title of certifier

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29d. Dale signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Wicks THE MD.

301

Hospital Drive, Glen Burnie 21061

Jeorge 31. Date filed (Month, Dey, Year)

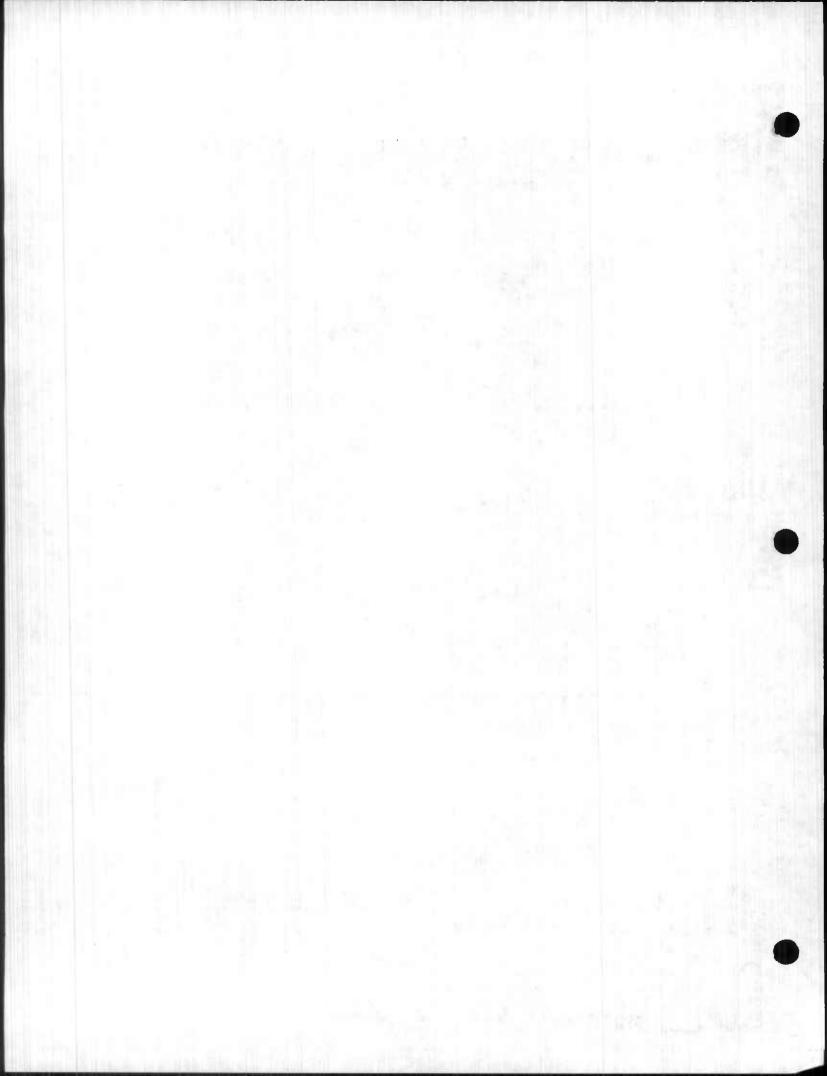
2 Accident

3 Suicide

29a. Certifier

4 Homicide

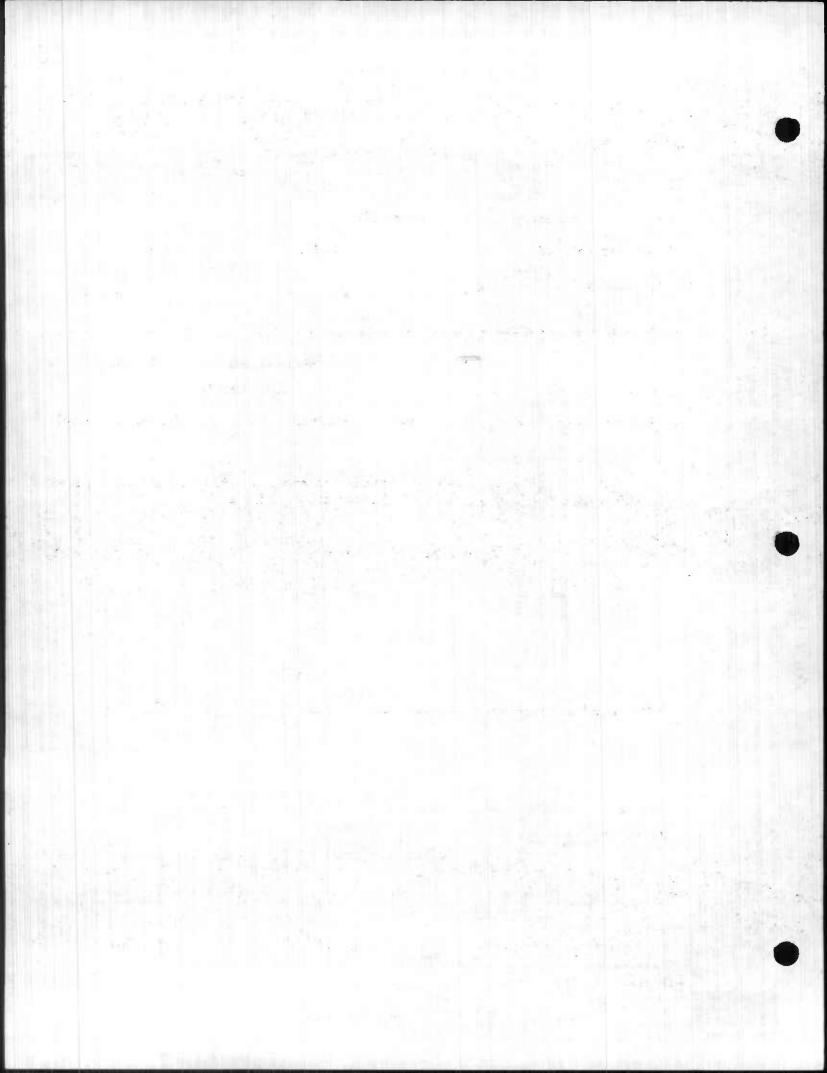
32. Registrer's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amended item #1	5 per fh g782 4/11/2000	•	Department of F		Reg. No	0 0	11685		
Physician	1. Decedent's Name (First, Middle, Last) ELIZABETH K. PEELING		Date of Deeth MCH 20, Di	2000 Year	3. Time of Death 9:05 AM				
/Medical Examiner	4a Facility Name (If not institution, give street and 14304 Parkvale Road	tb. City, Town, or Locati Rockville		c. County of Death Montgome 1	у				
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last I	lest birthday) Yrs.   If Under 1 Year   If Under 24 Hrs.		8. Dete of Birth (Month, Day, Year) Apr 27, 1918		Birthplace (State or Foreign Country) DC		
. po Ma	Usual Residence of Decedent  10a. Stete 10b. County	10c. City, To	wn or Location			1	10d. Inside City Limits		
n the Maryland r 28e-f show molfred at	MD Montgomery Rockville						1 ☐ Yes 2X No		
th with the 23s or 28s unit be not	10e. Street end Number 14304 Parkvale Rd		10f. Zip Code 20	853	10g. C	itizen of What Coul USA	ntry?		
020 urs after dea alt, or items transfret m	1 Never Married 2 Married 1 Yes,	ecedent Ever In U,S. I Forces? es 2 \textbf{\textit} No Give or Dates:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☒ No	lispanIc Origin? (Specify en, Mexican, Puerto Rice Specify:	Yes or No- in, etc.)	14. Race - Americ Biack, White, Specify: White	etc.		
ind 21215-0020 be filed within 72 hours aff tal Hygiene. d other than "natural", or event, the Wedical Exam Be Completed by F	15. Decedent's Education (Specify only highest grade complete Elementery/Secondary (0-12)  College	cupation 16b. Kind of Business/industry ne during most of working irred)							
L 21	12 +5	-	L	ibrarian 18. Mothers Name (Fi	ret Middle Maide	educatio	on .		
B salaby B	Alfred Keim			Alma H		Joinanie)			
Marylan d 2 should be th and Mental 7 la marked our traumatic events.	19a. Informant's Name/Relationship (Type, Print)	11	9b. Mailing Address (Street			or Town, State, Zij	Code)		
Mand 2 and 2 and 2 la n 27 la	Teresa James/daughter		14601 Zane C:	ircle Hunt	ington B	each, CA	92647		
Baltimore, Mpenit. Pages 1 and Department of Health Important: If item 27 any injury or other trents.	20a. Method of Disposition 1 ☐ Bunial 2 ☐ Cremation 3 ☐ Removal fro 4 🛣 Donation 5 ☐ Other (Specify)	20b. Place	of Disposition (Name of tery, crematory or other place			ocation - City or To			
Balt permit. Depart importu any inje	21. Signature of Funeral Service Licenses  Royald S. Wade, Director  22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street  Baltimore, MD 21201								
Physician	Approximately a Part Lenter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, interval on the father. List only one cause of fach line.  Approximately a control of the cause of fach line.								
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)  a.   Mut. Sie Myele								
in a series	<b>—</b> b								
68760, icate be executed physician and s the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Infligry that Initiated events control to death). Leat Due to (or as a consequence of):								
O. E e deal the art the art for red for reich	Part II. Other significant conditions contributing to	23b. Did tobacco use contributa to the cause of death?							
IS, P.O as that the igned by the be detache by Phys	AmyloiDos	1 Yes	I Yes 2 No 3 Probably 4 Ur						
cord requir	24a. Was an autopsy performed?						24b. Were autopsy findings available prior to completion of cause of death?		
II Rec The law page 2:					1 ☐ Yes	200 No 1	☐ Yes 2☐ No		
Vital I icien: The certificate rector, pag	25. Was case referred to medical examiner?								
on of Vita fing Physician: After this certific funeral director,									
iding i ding i th.		Nonth, Day Year)	Injury Wor	rk? Yes 2□No	Zodi Zodiko iku injerji dadane				
Division of standing P as a state death in Division of the tuner of in by the funeral Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of Town, State)								
Division of Vita To the Hospital or Attending Physician: Whin 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director, Medical Certification: To Be (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the comp	29b. Signature end title of confiller						igned (Month, Day, Year)		
	(362	> 201069			3 27 100				
	30. Name and address of person who completed of EDGAR LEVIN 98	ause of death (Item 23s	(Type, Print)	SILVE	2 808	eng, m	5		
State Registrar	31. Dete filed (Month, Day, Year) APR 1 1 2000	2. Registrar's Signature	& Spa	Ka					



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1686 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** SHEILA MARY PARKER 2200 APRIL 06 Baw /Medical 4e Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MERCY MEDICAL CENTER HOSPICE BALTIMORE 5. Social Security Number 7. Aga (In yrs. last birthday) If Under If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 07/08/1935 Birthplaca (Stata or Foreign Country) **Funeral** Months 1□M 20 F Days Hours 331-28-5070 64 Director ILLINOIS Usual Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f MD BALTIMORE PERRY HALL å 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 munt be 41 CHESTHILL COURT 21236 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 272 No If Yas, Giva Year or Detas: 14. Raca - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, White, atc. filed within 72 hours after 1 Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 8 1 Yas 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) OCCUPATIONAL Elementery/Secondery (0-12) College (1-4or 5+) Hygians. THERAPY 4YRS OCCUPATIONAL THERAPIST 17 Father's Nema /First Middle Last 18. Mothar's Nama (First, Middle, Meiden Sumema) Pages 1 and 2 should be to ment of Health and Mental H ant: If Item 27 is marked oth lary or other traumatic even Be HAROLD W. PARKER CATHERINE KENNY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) EILEEN F. PARKER(SISTER) 41 CHESTHILL CT. PERRY HALL, MD. 21236. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ■ Burial 2 □ Crametion 3 □ Removal from Stata Department or important: if any injury or MEDICAL MISSION CEM. 04/11/2000 PHILA., PA. 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility HENRY W. JENKINS & SONS CO 4905 YORK RD. BALTO., MD. 2 esna. 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final years Breast Corcinous disaasa or condition rasulting in daath) Examiner Dua to (or as e consequança of) Examiner The law requires that the death certificate be executed burial-trans Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or injury that initiated events resulting in daath) Last Dua to (or as e consequence of): Box 68760, physician Physician/Medicai the Dua to (or as e consequença of) 88 for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25€No 3 Probably 4 Unknown Records, Completed by 24a. Was an eutopsy performed? 24b. Wara autopsy tindings aveilable prior to completion of cause of death? page 2 certificate 1 Yas 300 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 8 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Nothar (Specify) HOSPICE 1 Yes 2 200 Medical Certification: To this 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Natural 5 Panding 1 | Yas 2 | No investigation 2 Accidant within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred at the time, dete and place, and dua to the causa(s) and mannar as stated.

Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifian completely (Check only one) \$ 29c. License number 29d. Data signed (Month, Day, Year) 10 lear MS 30. Nama and address of person who complated cause of daeth (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State Registrar 31. Data filed (Month, Day, Year)

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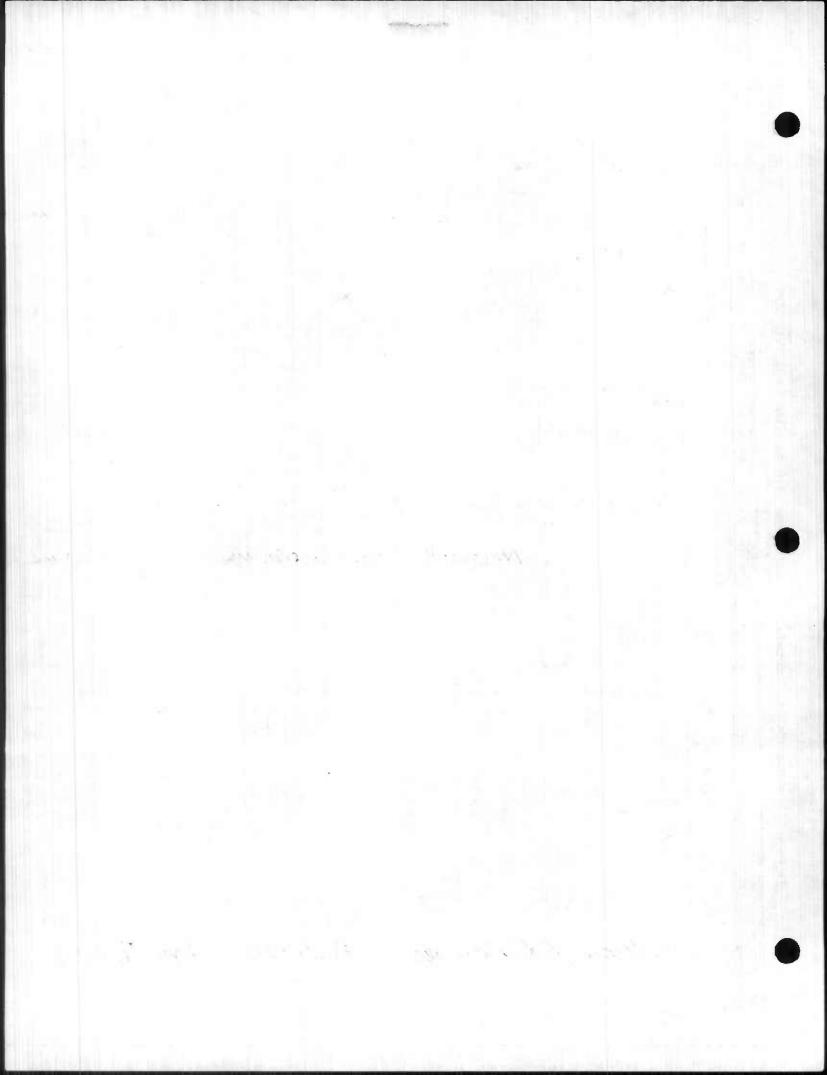
FELDMAN, M.D. 301 32. Registrar's Signature

**ORIGINAL** 

ST. PAUL

PLACE # 407T

BALTO, MD. 21203

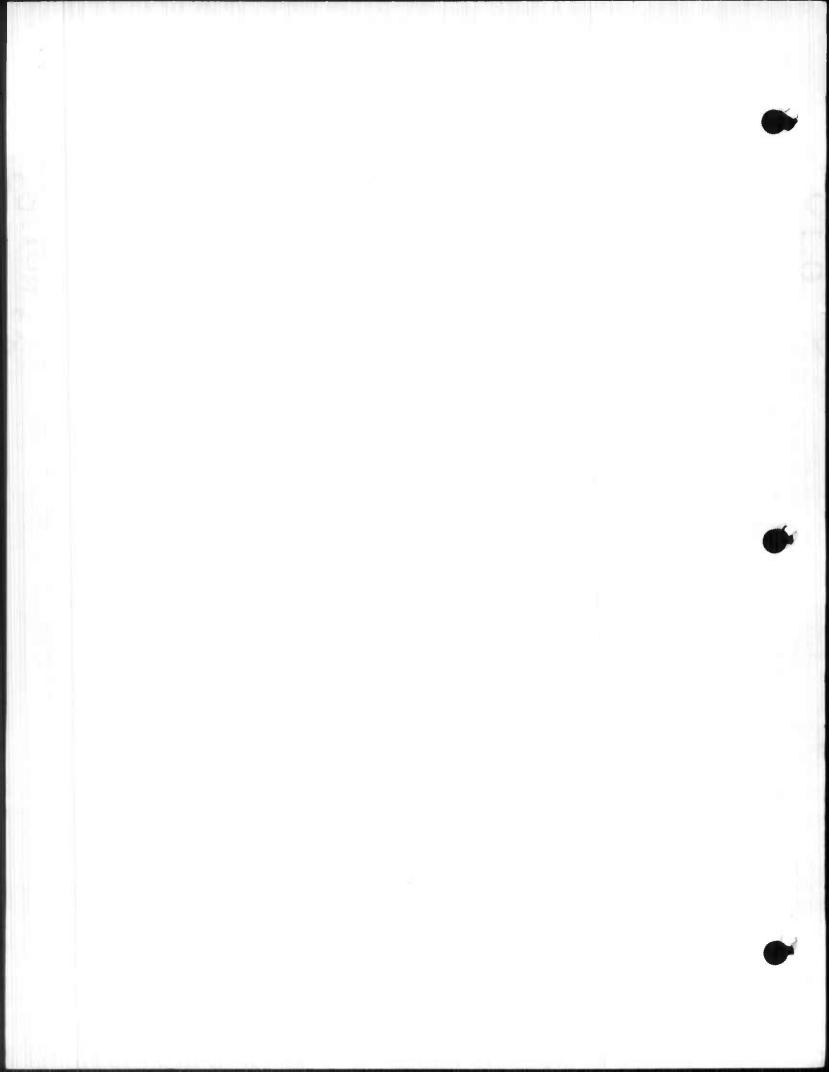


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		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		1. DECEDENT'S NAME (First, Middle, Lest)	Paise				2. DAT	E OF DEATH	NY )	YEAR 3.	TIME OF DEATH
	DIRECTOR		SEX 6. AGE (	In yrs. last birthday)  74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	E OF BIRTH		Country)	ACE (State or Foreign
should		9a. FACILITY NAME (If not institution, give street		( ,) D		OR LOCATION OF D	PEATH	192	9c. COUNTY		RGINIA
1, 2, 3		PRESIDENCE OF DECEDENT	7700 90	K RU		sim			Bul	tim	ne
permit. Pages	DIRE	MARY LAND	NIA	10c. CIT	ry, town or local	ALTIM	INR	E Ci	TV	100	d. INSIDE CITY LIMITS? YES 2 NO
sit perm	FUNERAL	100. STREET AND NUMBER	ARATOG	A ST	REET 10	f. ZIP CODE	10	22		N OF WHAT	T COUNTRY?
physician. burial-transit			P. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	CENDENT OF HISPA	NIC ORIGI	IN? (Specify Yes Rican, etc.)	or No — 14	I. RACE — Black, W	American Indian, hite, etc.
ending as the	COMPLETED BY	3 Widowed 4 Divorced  15. DECEDENT'S EDUCAT	IF YES, GIVE WAR OR DA		1 - YES	S 2 A NO Speci				Specify:	BLACK
for u		(Specify only highest grade con Elementary/Secondary (0-12)		(Give kind of life. Do NOT u	work done during me	ost of working	16	b. KIND OF BUS	INESS/INDUS	TRY	
the hospital detached for once.		17. FATHER'S NAME (First, Middle, Last)		MAIN	VIENA	NCE MAI		Middle, Melden		Co	MPLEX
5 should by notified at	BE	SHEDRICK  190, INFORMANT'S NAME (Type/Print)	P	AGE 196. MAJLING	SR, ADDRESS (Street a	BE /	RTT.	tA	State Zin Co	77to	OMAS
De 5 Ge 5	5	JOSEPH PAGE 200. METHOD OF DISPOSITION	JR (SON)	5/2	9 SEKO	TSRO	. APT	TB4, 13	ALTO.	HD.	21207
e 6 m ector,		12 Surial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	trom State	PLACE AND DATE etery, crematory or o		ame of METER V	1 4-13		NSOO	OF TOWN,	Store HARVLAND
death. Page 6 m tuneral director, i.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  TOSEPHH, BROWN JR. FUNERAL HOME									
after by the emova		23. PART I. Enter the diseases, or com shock, or heart fallure. List	plications that caused	the death. Do	not enter the mo	O N F	th as car		atory arrest	0, HL	Approximate
E 0.		IMMEDIATE CAUSE (Final disease or condition NEUMONIA.								Interval Between Onset and Death	
P 6 - 5		resulting in death)	DISC TO 100 10 1				7	<u> </u>			YEARC
8 0 5		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
certificate be in graphysician ygiene prior to other traun	MIFIC	CAUSE (Disease or Injury that Initiated events resulting in death) LAST									
the death certificate by the attending phyod Mental Hygiene pinjury, or other	L CER	d	Ontributing to death hi	at not resulting	In the underlying	a ceuca alma la	Dort I	T a.z. uma a.z.			
× and at	MEDICA	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part						PERFORMED?		CON	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION DF CAUSE DEATH?
		DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YE	S NO/	UNCERTAI				1 [	YES 2 NO
N: The law ficate has t State Dept item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  HOSPITAL:  OTMER:									
certific the		27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ	PIK?		er (Specify) SCRIBE HOW IN	JURY OCCUR	IED	
ATTENDING PHYS ECTOR: After this s after death with	D BY	Accident Investigation  3 Suicide 8 Could not be	28s. PLACE OF INJURY building, etc. (Speci	— At home, farm,		YES 2 NO	28f. LOC	CATION (Street at	nd Number or	Rural Route	Number,
DIR.	LETE	4   Homicide datarmined									
3 40 =	COMPLETED	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated.    CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: I	BE	296. SIGNATURE AND TITLE OF CERTIFIER		_	MIX	29c. LICENSE NUI	MBER 27.	19	29d. DATE SI	1 1	nth, Day, Year)
	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TYPE PIPE) 21236.									
4		31. DATE FILED (Month, Day, Year) APR 1 1 2000	32. REGISTRAR'S SIGNA	TURE 4	local						
	- 1		/	1-	MAN COUNTY						

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1688 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month MARGARET THEFIN 02:14AM 04 00 4c. County of Death 4e Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth UNIVERSITY OF MARYLAND

5. Social Security Number 6. Sex 17 PALTIMORE If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplece (State or Foreign Abuntry) 15-12-0075 1□M 2XF Days Hours Months Yrs. Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Pr did 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian. 11. Merital Stetus Bleck, Whita, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) re 19a. Informant's Neme/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 21 lada Se me 121 20b. Place of Disposition (Name of cemetery, crematory or other p / Dete 20a. Method of Disposition 20c. Location - City or Town, Stete ery, crematory 1 Burial 2 Cremetion 3 Removel from Stete 13 2000 Vationa 4 Donetion 5 Other (Specify) Timore 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Russ tu Funeral ! ve. Balto. Joseph tome ent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, hock or heart leiture. List only one cause on each line. Approximata Intarval Between Onset end Death Immediete Cause (Finel WEEK diseasa or condition resulting in deeth) Dua to (or as a consequence of) NEUTROPENIA 2 WEEKS Due to (or as a consequence of): HEMOTHERAPY 3 WEEKS Due to (or as a consequence of): MYELOGENOUS EUKEMIA ACUTE Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 🛣 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Menner of Death

**Physician** /Medical Examiner

physician and the burial-tranait

for usa as

detached

signed by t

certificate

this funeral

After or Attending

within 24 hours efter death.

To the Funerel Director: Af
completely filled in by the fu

Hospital

To the I within 2

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Completed

Be

Certification:

USB

Box 68760,

P.0.

Division of Vitai Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ahow

Nerna 23a or

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"naturaf"

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Medical 2008.

Baltimore, Maryland 21215-0020

Director

þ

Completed

Be

traumatic event, the Medical Examiner must be notified at

Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initieted events rasulting in death) Lest Physician/Medicai

25. Was casa referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be

28a. Dete of Injury (Month, Day Year)

28b Time of

28e. Plece of Injury - At homa, lerm, street, lectory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28l. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1 Natural

2 ☐ Accident 3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

Kachna -Gupta 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

DD

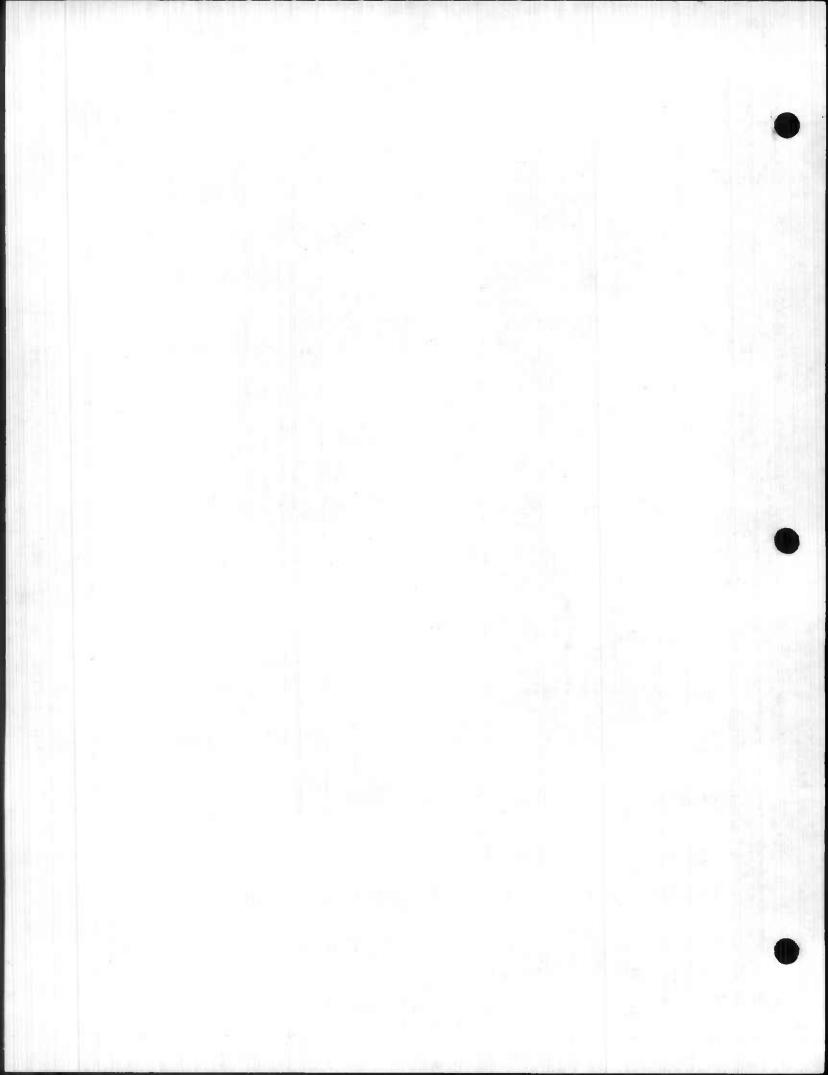
GUPTA 31. Date filed (Month, Dey, Year) APR 1 1 2000 State

GREENE S 32. Régistrer's Signeture

BALTIMORE, MD 21201 STREET oour

Registrar

DHMH 16 Ray 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Yeer 17:31 Dorothy Ruth Richards 2000 APRIL 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORG ST. AGNGS HOSPITAL 5. Sociel Security Number 6. Sax If Undar 1 Year If Undar 24 Hrs. Months Deys Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) 10 M 20 F Deys 219-20-7992 Vrs 92 OCT 7, 1907 UNK. Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☑ No Catonsville 10e. Street end Number 10f. Zip Code 10g. Citlzen of Whet Country? 333 Harlem Lane 21228 USA 12. Was Decedent Ever in U,S. Armed Forcas? 11. Meritel Status Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1□ Yas 2HNo Black 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) UNK. Factory Worker Canning Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK. UNK. 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dawn Kalthof/friend 333 Harlem Lane Catonsville, MD 21228 20b. Piece of Disposition (Name of cemetary, crematory or othar place) 20e. Method of Disposition 20c. Location - City or Town, State 1 □ Burlal 2 XCremetion 3 □ Removel from Stata 4 □ Donetion 5 □ Other (Specify) Metro Crematory, Inc. 4/11/00 Baltimore, MD 21. Signature of Funerel Service Licensee Cremation Society of Maryland, Inc. nostegor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. BREAS/ADENO CARCINOMA Immediate Ceuse (Final UNKNOWN disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequence of) Due to (or es e consequença of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were autopsy findings evellebla prior to completion of causa of deeth? 1 ☐ Yes 20 No 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 ☐ Yes 2 No

attending physician and for use es the bunal-transit The law requires that the deeth certificete be axecuted this certificate Affer

Examiner Physician/Medical Be Completed by Certification: To

edicai

27. Manner of Deeth

Naturel 2 Accident

3 Suicida

29e. Certifier

4 Homicide

(Check only one)

29b. Signature and talls of certifier

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

0

\*natural", or Items 23a

permit. Peges 1 and 2 should be filed within 72 hours after a Department of Hasith and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 1900.

**Physician** 

/Medical

Examiner

Director

Funerai

g

Completed

MD

traumatic event, the Medical Examiner must be notified at

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician:

DoRoTH

2ICHARDS efter deeth. 24 hours To the Hosp within 24 hos To the Fune completely fi

State Registrar

hospel 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ST. AGNES HOSPITAL, BALTIMORE 31. Dete filed (Month, Dey, Year) APR 1 1 2000

5 Pending Investigation

6 Could not be determined

32. Registrar's Signature

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury et Work?

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29c. Licanse number 29d. Dete signed (Month, Day, Year) P19600

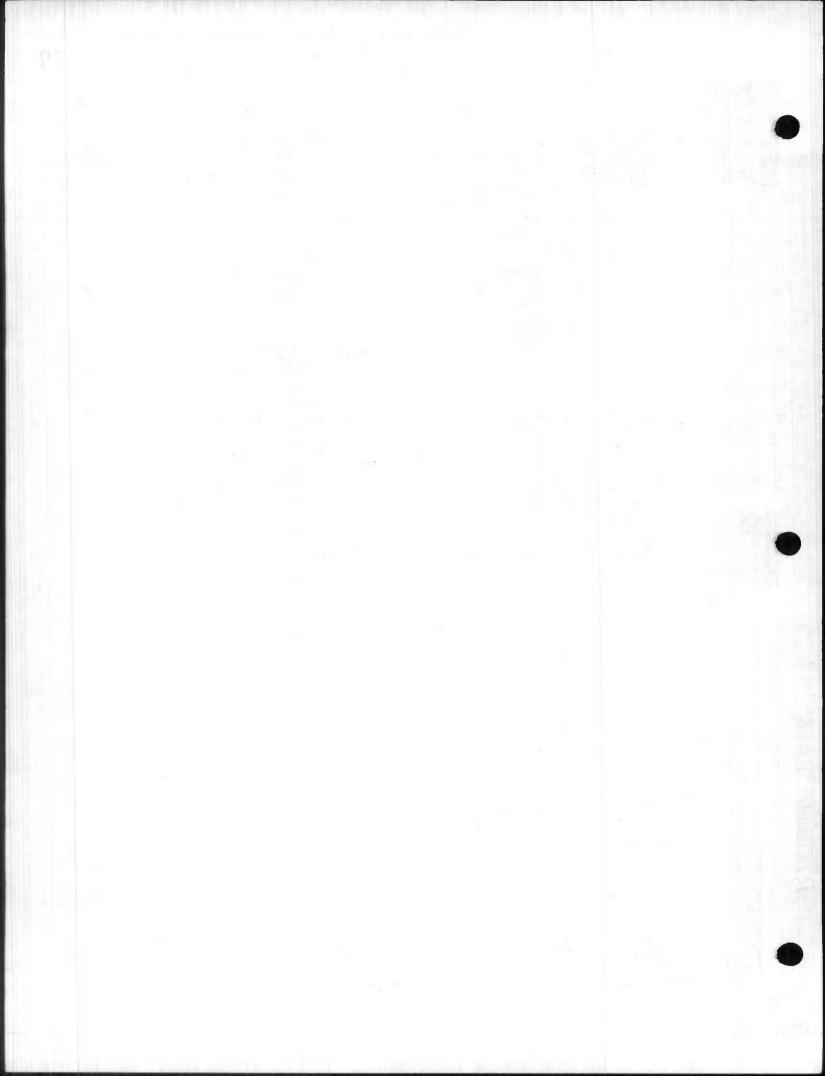
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

NASSER NASSERI M.D

**DHMH 16 Ray 6/95** 



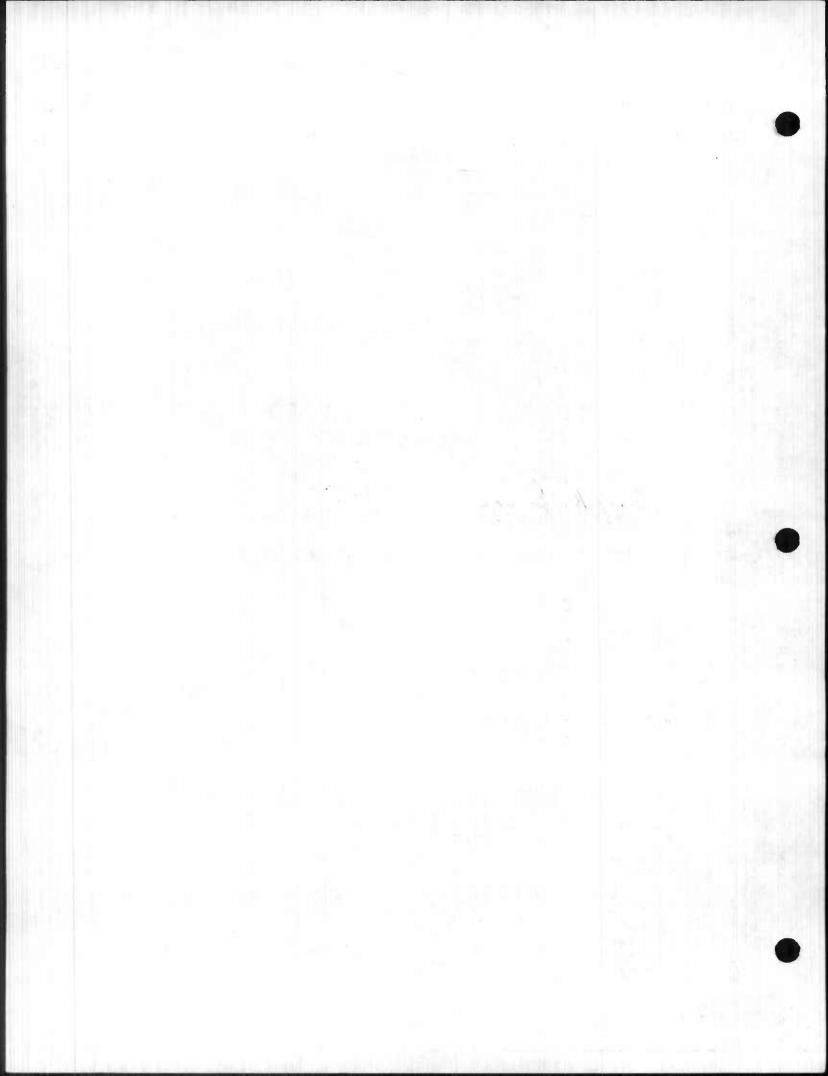
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** MARCH RICE **JAMES** ,2600 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HILL BXON If Under 24 Hrs. 1300 SOUTHVIEW PRINCE GEORGES DRIVE 8. Data of Birth (Month, Dey, Year) July 23, 1946 5. Social Security Number if Under 1 Year Birthplace (Stata or Foreign Country) 7. Aga (In vrs. last birthday) **Funeral** Months 577-64-2937 1€ M 2□ F Days Hours <del>52</del> 53 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show rait, or itema 23a or 28a-f ahov Examiner must be notified at Oxon Hill MD Prince Georges 1 Yas 2 □ No Director 10e. Street and Number 1300 Southview Drive #415 10f. Zip Code 10g. Citizan of What Country? with 20745 United States 1300 Southern Avenue, Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status should be filled within 72 hours after ond Mental Hygiene.
marked other than "natural", or there 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0020 If Yas, Giva Year or Dates 1 Yes 2 No Specify: þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) traumatic avent, the Madical 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12th Printer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Mary Browning James Scott Rice 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Code)
78 Darrington Street, S.W., Washington, DC 20032 19a. Informent's Name/Ralationship (Type, Print) James R. Rice - Brother Health a Department of Health Important: If Itam 27 any Injury or other tr once. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State Data 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 3/1/00 Bladensburg, MD 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R. N. Horton Co. Morticians, Inc 600 Kennedy Street, N.W., DC, 20011 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate interval Between Onset and Death **Physician** ARTERIOSCUROTIC CARPIOVASCULAR PISCASE /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. physician s the buria Physician/Medical Dua to (or as a consequence of): SE for use Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by I 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 14BETES MELLITUS edicai Certification: To Be Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate has 2 No 1 Yes 1 Yas 2 No of Vitai or Attending Physician: 25. Was case rafarred to medical examinar? 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this uneral 28a. Data of Injury (Month, Day Year) 28b. Tima of injury 27. Mannar of Death 28c. injury at Work? 28d. Dascribe how Injury occurred Division 1 Accident 5 Pending invastigation within 24 hours after death. To the Funeral Director; A 1 Yas 2 No the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end plece, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end plece, and due to the cause(s) and manner stated. 29a. Cartifie completely (Check only one) 94 29b. Signatura 29c. License number 29d. Data signed (Month, Day, Year) of death/(Item 23a) (Type, Print) HOSPITAL 43001

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signatura



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Og -10:55 AM Sharon K Rinardi 04 -/Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore County Baltimoile If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months 50 Yrs. 219-58-1053 Director Jan. 9, 1950 Maryland Usual Residence of Decedent r 28a-f show notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ment be n 21239 1344 Gittings Avenue United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: py White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) State Government 4 yrs. Accountant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Doris Booth Μ. Ih and Mont 7 is marked traumatic Rinaldi, Jr. Nicholas J. 19a. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important of Health at important; if them 27 is n any Injury or other 20058. Baltimore, Maryland 1344 Gittings Avenue Mrs. Doris M. Rinaldi /Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4/12/2000 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 21. Signeture of Funerel Service Licensee Michael E. Canapp 22. Name end Address of Fecility 5305 Harford Road 21214 LEONARD J. RUCK, INC. Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPSIS 8 hrs Examiner Due to (or as a consequence of) Physician/Medical Examiner PNeumonia The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, use as the Due to (or as a consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the the 1 Yes 2 No 3 Probably 4 Unknown yd bengis Sclerosis Multiple of Vital Records, þ 99 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24a. Was en autopsy Be Completed certificate hes 1 Yes 2 No 1 Yes 20 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred After 1 Naturel 2 Accident 5 Pending after deeth. Director: Aft 1 Yes 2 No Investigation the 6 Could not be 3 ☐ Suicide 28e. Plece of tnjury - At home, term, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital e within 24 hours a To the Funeral D Medical 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) (Check only one) end menner stated

Division

Registrar **DHMH 16 Rev 6/95** 

State

22. S. Greene St Michael Akom MD 31. Date filed (Month, Dey, Year) 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ukam

32. Registrer's Signeture

Buttimose Manyland

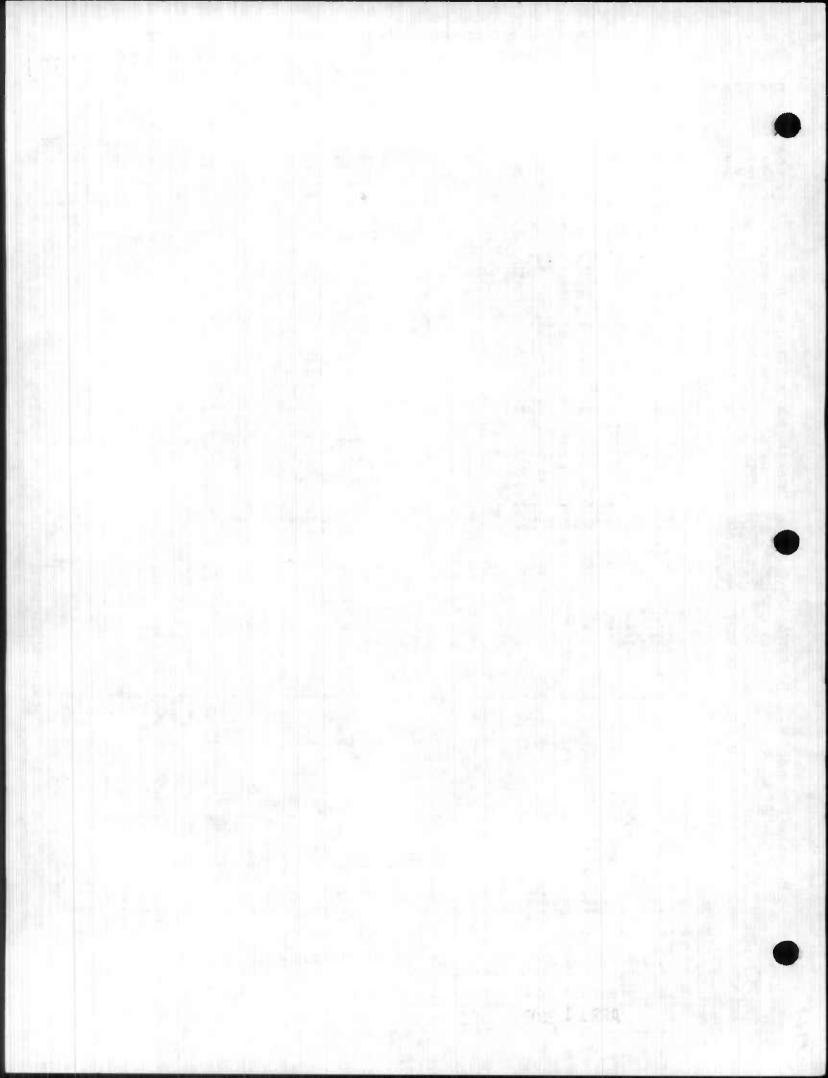
29c. License number

P13355

29d. Date signed (Month, Day, Year)

04/09/00

21217.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 12 24 PM Switzer (serald 04 09 00 ' /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Edical Center | Carrier | 1 State of Birth | 9. Birthplace (State of Fundar) | 1 Under 1 Year | 1 Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 7. Aga (In yrs. last birthday) | Months | Days | Hours | Min. | July 14, 1959 | New Hampshire Medical VA Baltimore 5. Social Securify Number 6 Sax **Funeral** XXM 2□ F 372-72-6816 Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at XXYes 2□ No Maryland N/A Baltimore Director 10e. Street and Number 3304 Keswick Road 10f. Zip Code 10g. Citizen of What Country? 21211 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11 Marital Status Armed Porces,
1 XYes 2 No
If Yes, Giva
Year or Dates: 1977-81 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within : Depertment of Haalth and Mentel Hygiens Important: if Item 27 is marked other than "n any Injury or other traumatic avant Cole & Sons College (1-4or 5+) Elementary/Secondary (0-12) Roofing Co. Roofer 11 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) Be Jerold Switzer Karin 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 Keswick Road Baltimore, MD 21211 Sharon Switzer Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington 4/12/00 Laurel, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211
Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hearn fallura. List only one bause on each line.

3631 Falls Road Baltimore, MD 21211
Approximation for the mode of dying, such as cardiac or respiratory errest, intervel Be Onset and Constant and Con Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) hemorrhage 48 hrs. Subarachnoid Examiner Disseminated Intravascular Coagulation sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that lotilated events rasulting in death) Last Due to (or es a consequence of): physician sthe burial Box 68760 Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Cirr hosis Division of Vital Records. Aq 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed Renal Failure completion of cause of deeth? Human Immunodeficiency Virus 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Deeth (Check only one) Be Hospitel: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of Aftar 5 Pending Investigation 1 Netural or Attendination of the death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a 24 hours 29a. Cerrier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the within 2 29b. Signature and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 4-09-00 address of person who completed cause of death (Item 23a) (Type, Print) Center 10 N. Greene St Baltimore VA Medical

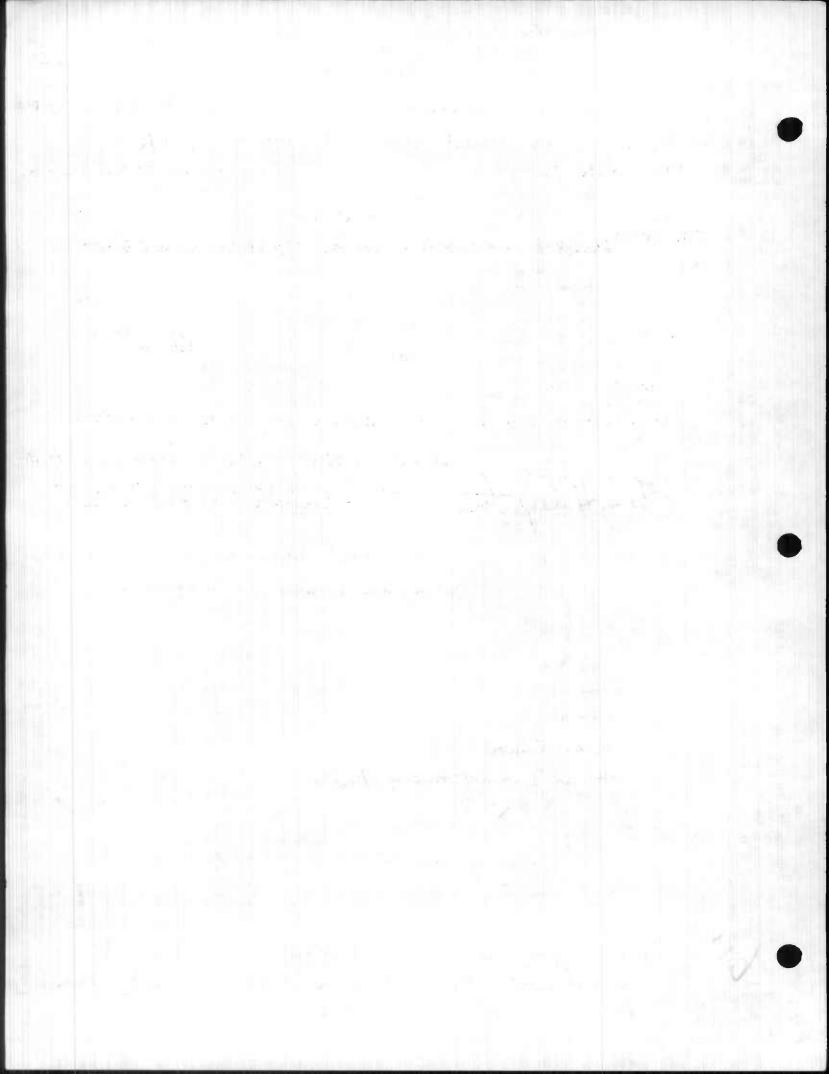
**DHMH 16 Rev 6/95** 

Registrar

31. Date filed (Month, Day, Year) APR 1 1 2000

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MD, Madhirain 32. Régistrar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:50 PM APRIL 09, 2000 Robert R. Seibert, Sr. 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (Stete of Country) Dec. 25, 1924 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign 1 M 2 F Months Days Yrs. 75 218-12-0684 Usual Residence of Decedent 10a. State 10b, Count 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Maryland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1229 Union Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status VOYes 2 No fryes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3€Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Johns Hopkins Sheet Metal Mechanic 9 Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Wilbur Seibert Gertrude Jacob 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 1210 MD Pamela Seibert Daughter in 310 Ridgemead Road # 310 Baltimore, Lake View Memorial 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/14/00 Sykesville, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Entert he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TETASTATIC COLON CANCER 4 MONTHS Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DEHYDRATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy PNEUMONIA 1 Yes 2 No 1 Tyes 20 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending

Examine The lew requires that the death certificete be executed Box 68760. attending physicien for use as the buria Physician/Medical Division of Vital Records, P.O. signed by the p Completed certificate has pega or Attending Physician: Be 10 this Certification: After after death.

Director: Aft
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within 24 hours a To the Funeral C To the Hospital

DHMH 16 Rev 6/95

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/Medical

Examiner

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Completed

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filed within 72 hours after death

Maryland 21215-0020

Baltimore,

25. Wes cese referred to medical 1 Yes 2 No 27. Manner of Death 1 -Natural Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

Minane

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\*PRIL 09, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

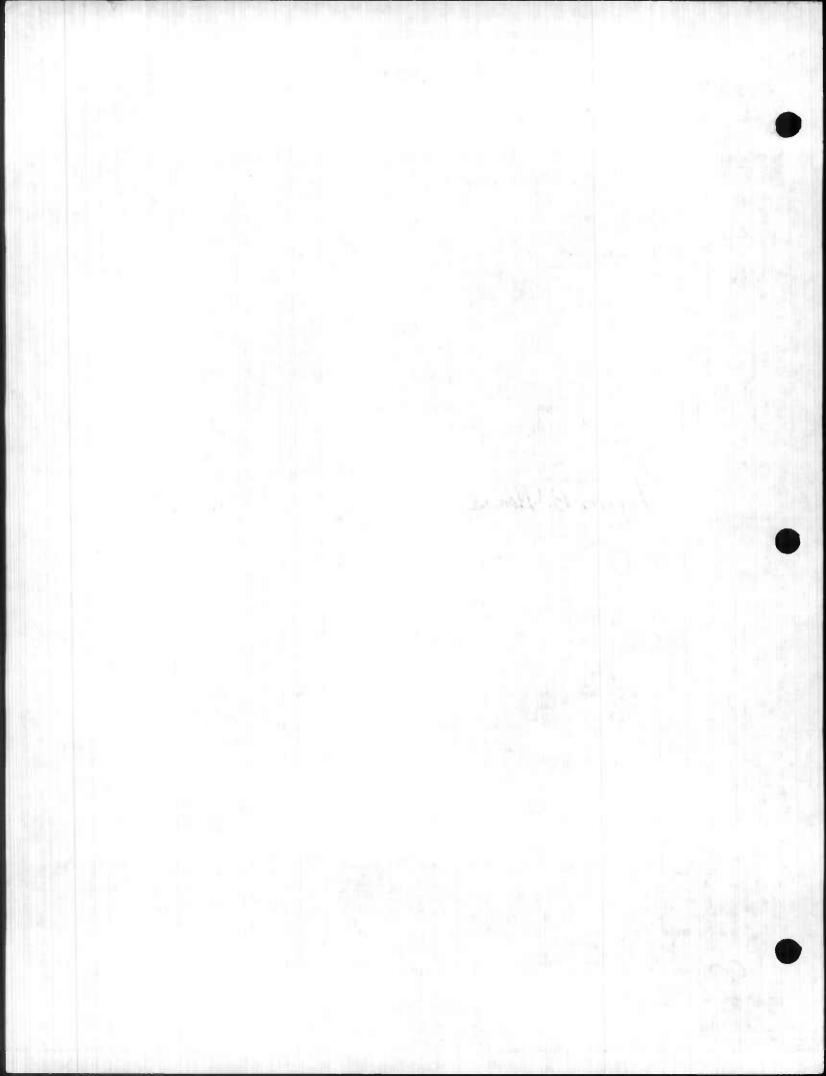
UNION MENG. HOUP, BALTIMORE, MD 21218 JOSEPH PUTITUMANA,

State Registrar

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31. Date filed (Month, Dey, Year) 2000 APR 11

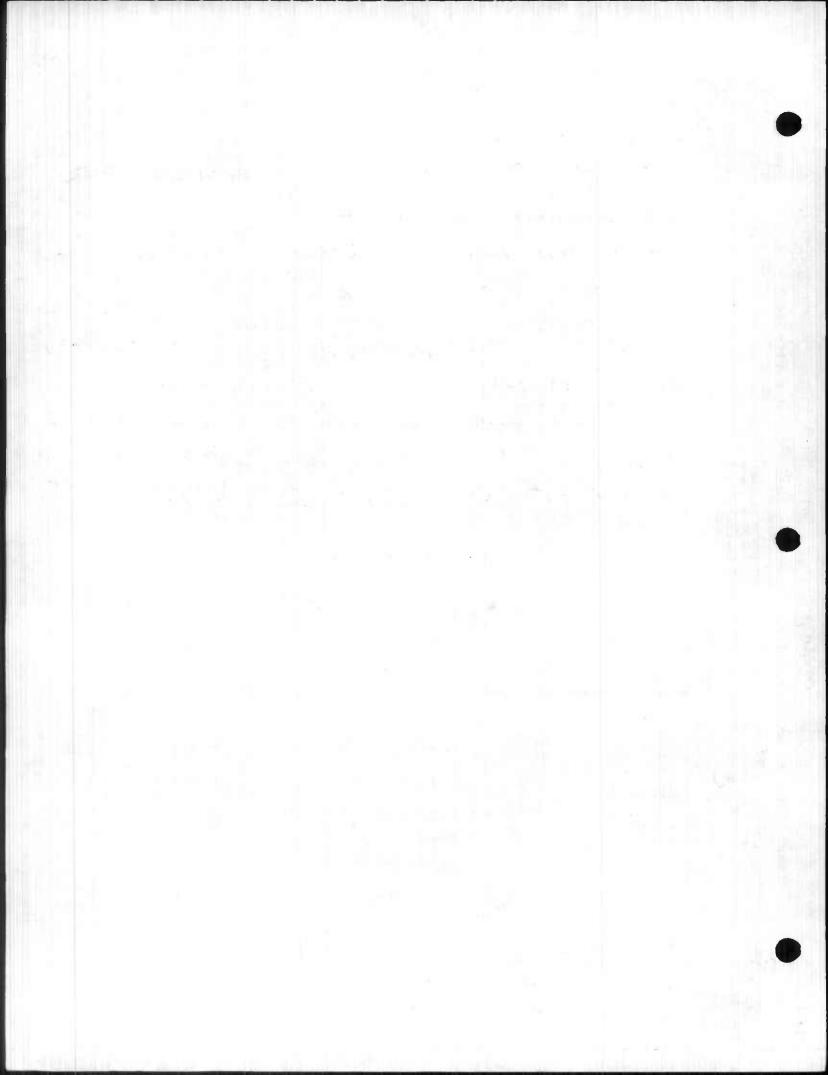




Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year APRIL **Physician** Smith 4:20 PM 7, 2000 4c. County of Death, nnie /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Stella Maris Baltimore HOPICE Timonium If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Qay, Birthplace (State or Foreign Country) **Funeral** Hours 119-40-8240 Months Days 10 M 20 F 74 Yrs. Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow MP Baltimore atonsul 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 134 Winters 21228 United States Lane Herna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. the Medical Examiner 1 Never Married 25 Married 1 Yes 2 No "natural", or specify: Black Specify: 2000 by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Nursing Assistan April Maryland 17. Father's Name (First, Middle Last) 18. Mother's Name, (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be nent of Health and Mental William Staward Griffin annie 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windmill Rd. permit. Peges 1 and 2 Department of Health e Important: If Item 27 le any Injury or other tra-once. Priscilla Campbell Daughter 8621 Randallstown, MO 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April Reisterstown, mo 1 Denial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Luke Cemetery 22. Nama and Address of Facility 21. Signature of Funerei Service Licenses Home, P.A. FUNERAL SMITH & WILLIAMS aloun Lo 2818 €. Baltimore St. Bulto, 140 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical a. END STAGE ALZHEIMERS DEMENTIA Examine Due to (or es a consequence of): Examiner physician and the burial-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sutopsy performed? The law 1 Yes 3 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence (X)Other (Specify) HOSPICE 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? edical Certification: After or Attending 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No hours after death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 ☐ Homicide To the Hospital within 24 hours 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier completely (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)43725 10/11/00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar Gignature State Registrar 1 2000 **DHMH 16 Rev 6/95** 

Smith

**ORIGINAL** 



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey **Physician** CATHERINE M. SWIFT 9 2000 MANCY /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner | Funder 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) GOOD SAMARITAN HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days 54 Yrs. 214-44-1673 Usual Residence of Decedent Director THE 26,1945 MARY LAND the Manyland 10e State 10c. City, Town or Location 10h County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumatic avent, in Medical Exercises must be notified at 1 Yes 2 □ No Director MD NA BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 by Funeral 54 // CRESTON AVENUE filed within 72 hours after deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 CUTTER MATERIAL GARMENT MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be finent of Health end Mental First If Item 27 Is marked ot 2 JANE MARCELENE BEALL ERNEST AUGUST RUHE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STER 1306 Q SCOTTS DRLE DR. Bol Air MD 2/0/5

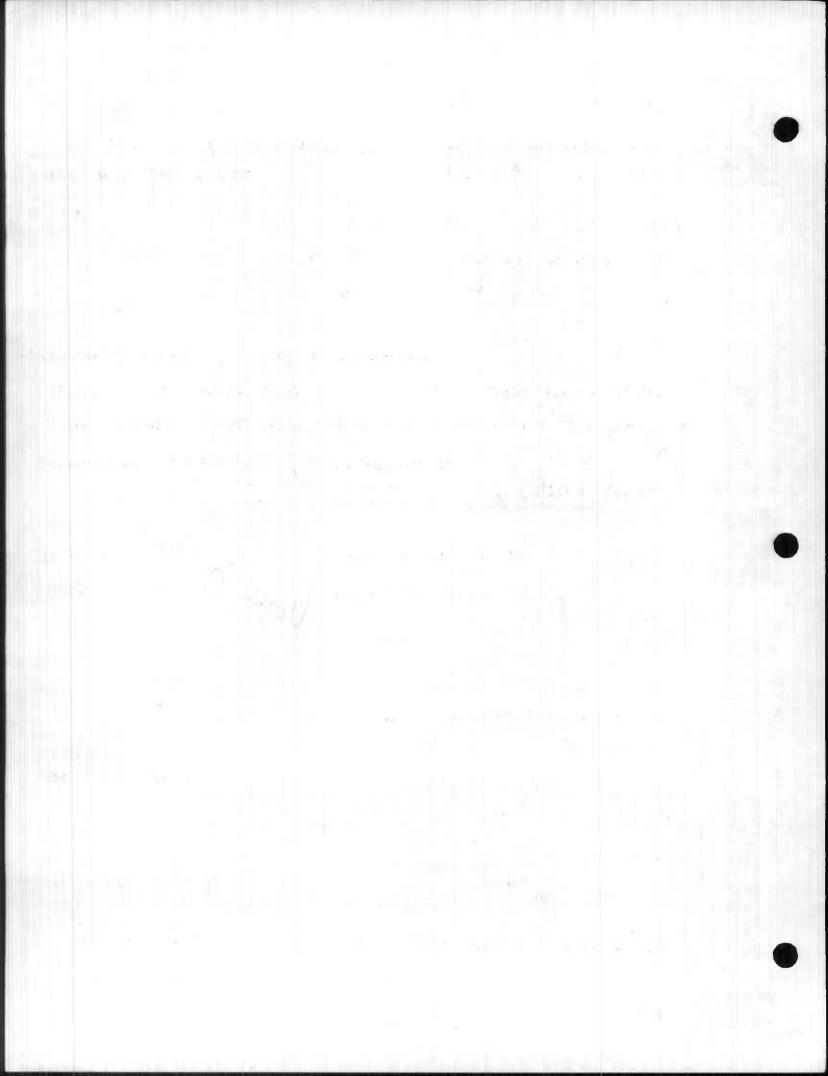
20b. Place of Disposition (Name of cometery, crematory or other place)

Date 20c. Location - City or Town, State MRS HANNAH I, RITTER (SISTER) or other t 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State permit. Page Department of Important: If eny Injury or 3/13/2000 PARKVILLE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD CEMETERY 3/13/2000 PAR 22. Name and Address of Facility ALTEN BURG FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 22. National and Address of Fundamental Service Licenses of Licenses of Fundamental Alternations of Fundamental Al 6009 HARFORD ROAD BALTIMORE, MD 21214 Wayse On the Free training to the state of t Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final CENEBAN EDEMA 5 DAYS disease or condition resulting in death) Examiner Examiner 5 DAYS INSULW UVERDUSE physician end s the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the at Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown INSHUM DEPRENDENT DIABERS MELLINS Division of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? DEPLESSIN his certificate hes to al director, pege 2 s 1 Yes 2000 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours eftar death.

To the Funeral Director: Aftar this certifical completely filled in by the funaral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how Injury occurred

PATIENT INTERTO EXUSS 28c. Injury at Work? 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of WINCH 5 2000 APRILOX. 5 Pending investigation 1 Natural 1 Yes 2 No 2100 PM 2 Accident INSULW 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide HUME 5411 CHESTUN MEMIE 21214 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier APRIL 1,2000 015135 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 1.5005 5601 LUCK ROVER BUD BARAME, MD 21239 MD 1 ENELUIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 11 2000 Registrar Coals QHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death Year Physician 5: 11/1r 2000 /Medical acility Nama (If pot institution, give street and number) 4b. City. or Location of Death 4c. County of Death Examiner Mustrepkers 7. Aga (In yrs. last birthday) I 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 10 M 20 F Months Hours 242-42-93 Director Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental hygiene. Int. If Item 23a or 28a-f ahow int. If Item 27 I ar marked other than "natural", or items 23a or 28a-f ahow any or other traumatic avant, The Maryland Emergene The Hydine at 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Bultimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S. A. Bowland shours to make a should be seen a seen as a seen a 12. Was Decedenf Evar in U,S. Armed Forces? 1 Yas 2 No 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marifal Status 1 Nevar Married 2 Married 1 Yas 2 No Specify: 21215-0020 Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) abore grade Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Street W16618 Alice Conningham 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Street Bowland Are. Hazel 20b. Place of Disposition (Nama of corpotary, crematory or other p 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation Ther (Specify) Department of Important: If any Injury or 14/00 2 Dutus 21. Signature of Funeral Service Licenses 22. Nama end Address of Facility Ba 160 toneck elle 23a Par 1. Entar tha diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona ceusa on aach lina. 2/2/3 Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disaasa or condition rasulting in death) Examiner Be Completed by Physician/Medical Examiner igned by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata cause. Enfar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Dua to (or as a consequence of): P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes WNo 3 Probably 4 Unknown Division of Vital Records, 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes or Attanding Physician: 25. Was case refarred to madical axaminar? 26. Place of Death (Check only one) Hospitel: 12 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mennar of Death Naturaf Accidant funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Panding invastigation To the Hospital or Attandir within 24 hours after deeth. To the Funeral Director: At 1 Yas 2 No the 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. 29e. Cartifier (Check only one) 29b. Signature and fittle of certific 29c. License number 29d. Data signed (Month, Day, Year)

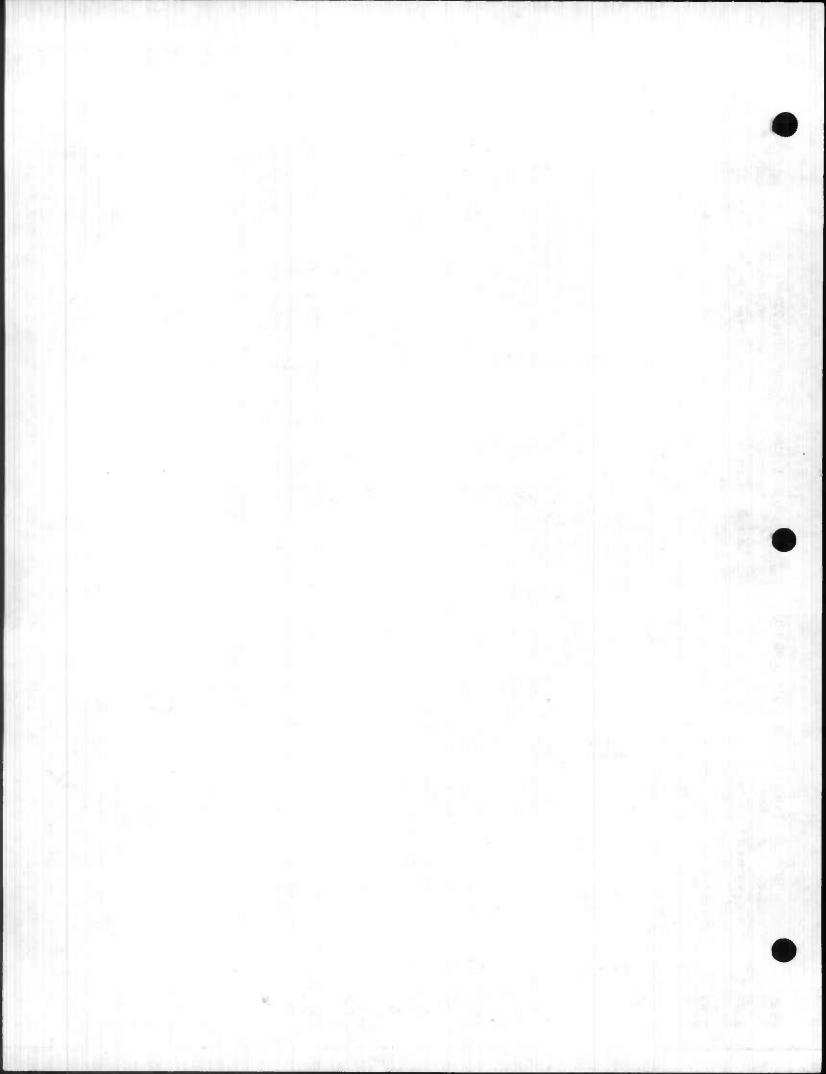
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

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no completed cause of death (them 23a) (Type, Erint)

32. Registrar's Sig



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Marquerite 10:35 Ar 102000 4a Facility Name (If not institution, give street and nur 4b\_City, Town, or Location of Death 4c. County of Death hus Hoperus GE NIA PLATATCS (KATE) 7. Ago (In yrs. last birthday) LMOLK H Under 24 Hrs. Hours Min. 8. Dele of Birth (Month, Day, Year) 3 - 12 - 27 If Under 1 Year 9. Birthplace (State or Foraign Country) Months Days 1□ M 2 F 73 251-30-8201 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1426 2/2/3 U.S. A Bund Street 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 (2010) If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 20 No Specify Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lacondry 10 1 snade oresser 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Hennelata Cornish Elijah Conknown 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1426 Bond 8t Bello Ml. 2/2/3 Anthony Deas (son) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Sleta 1 Burial 2 Cremetion 3 Removel from Stata 4/18/2000 Bello. Md. MT. Zion Cemetary 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bells Funeral Home 21. Signature of Funeral Service Licensee Ballo Md. 2/2/5 n. Cardine 1129 Street 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Between Onset and Death Immediate Cause (Finel PEMENTIA YRS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Ulcen, Schizaphrenia 3 Probably 4 Unknown 1 ☐ Yes 2 No De cub, his 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yas 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. tnjuny at Work?

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

altimore, Maryland 21215-0020

Pages 1 and 2 should be filled within in and Mental Hygiena.

Director

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8

Examiner this cartificata After

P.O. Box 68760. ne Hospital or Attanding P n 24 hours after death. Ne Funeral Director: After t

MARGUCK 17

PANN To the Fune complately f To the To the To the F

Physician/Medical Completed Medical Certification: To

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier morther a notice

5 Pending investigation

6 Could not be detarmined

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

281. Location (Street and Number or Rural Routa Number, City or Town, Stete)

30. Nama and address of person who completed cause of death (Item 234) (Type, Print)

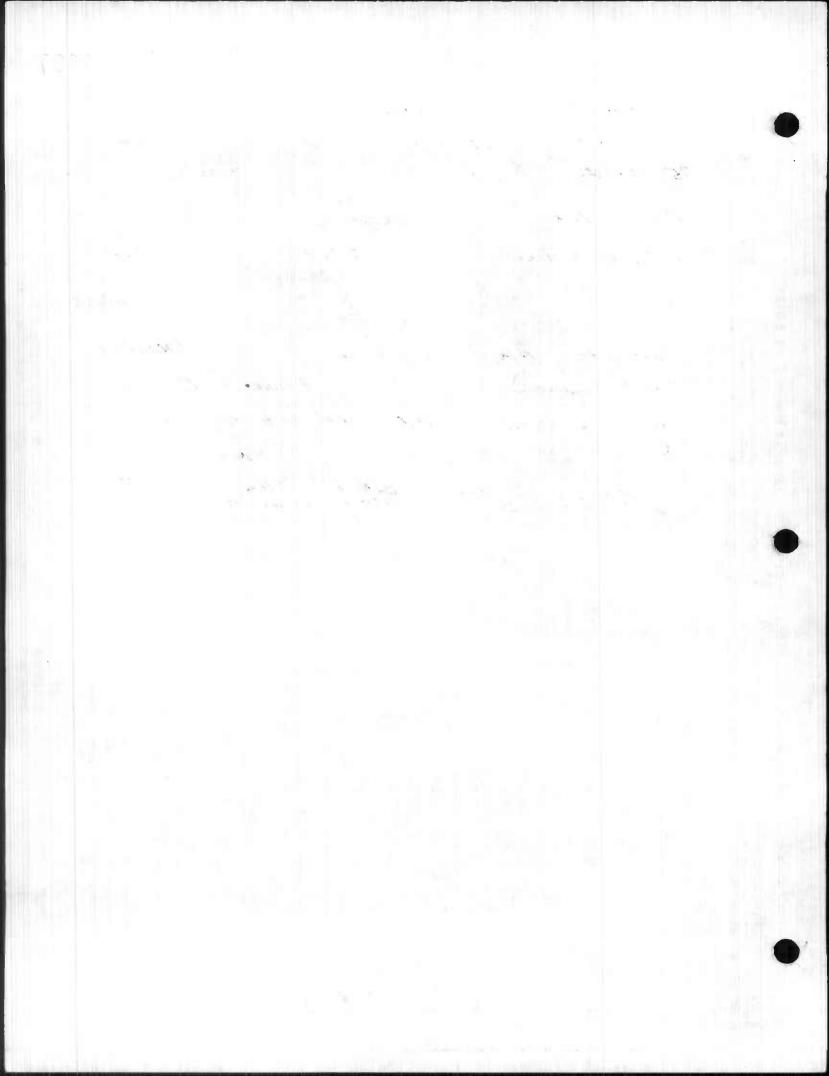
5505 HOPKINS BAYNIN CIRCLE BALT MD 21224

M CNAB NEY

31. Date filed (Month, Day, Year) 32. Registiar's Signature APR 1

Registrar

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Sheridan ewton March 2000 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth 7 Sudbrook La Kesville Wsq+ Rehab Pikesville Baltimore 7. Age (In yrs. lest birthday) | If Undar 1 Year | it Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 119M 20F 216-10-9749 97 JUNE 01,1902 Yrs. Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 2422 MC CULLO H STREET USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 14. Race - American Indian, Bleck, Whita, atc. 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxicen, Puarto Ricen, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 HHGRADE College (1-4or 5+) WAITER HOCHCHILD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) GOWEN JOHN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3927 BOARMAN AVE. BALTIHORE, NO. 21215 VIVIAN SHERIDAN REED (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal trom State AWN CEMETERY 04-03-00 BALTIHORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility, TOSEPHH 21. Signature of Eunoral Service Licensea BROWN JR. FUNERAL Home OSE 2140 FULTON AVE. BALTIMORE, MD. 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heer tailure. List only one cause on each line. Approximate Interval Batween Onsat and Death Immediate Cause (Final disaasa or condition resulting in death) Atherosclepti cerebral vasculer Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that Initieted events resulting In death) Lest Due to (or es e consequence of): Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to 24e. Was an autopsy completion of ceuse of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work?

The law requires that the death certificate be executed the buriel-tran P.O. Box 68760 signed b Records, cate has been signated by page 2 should b this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director; to

**Physician** 

/Medicai

Examiner

**Funeral** 

Director

28a-f show must be notified at

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itema 23a

"natural", or

filed within 7 I Hygiene. other than "n

permit. Peges 1 and 2 should be filed will Department of Health and Mantal Hygient Important: If Item 27 is marked other that any Injury or other trainment.

**Physician** /Medical

**Examiner** 

Examiner

Physician/Medical

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Be Completed

Certification: To

edical

Director

Funeral

by

Completed

the Maryland

72 hours after

altimore, Maryland 21215-0020

25. Was case reterred to medical examiner?

5 Pending investigation 1 Naturai 2 Accident 3 Sulcida

6 Could not be determined

28a. Dete of Injury (Month, Dey Year) Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28d. Describe how Injury occurred

MD

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner stated. 29c. Licanse number

29b. Signeture and title of cartitier

037373

29d. Date signed (Month, Dey, Year) 31,2000

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MO Park Hen JEF Zbell 7220

31. Date tiled (Month, Dev. Yeer)

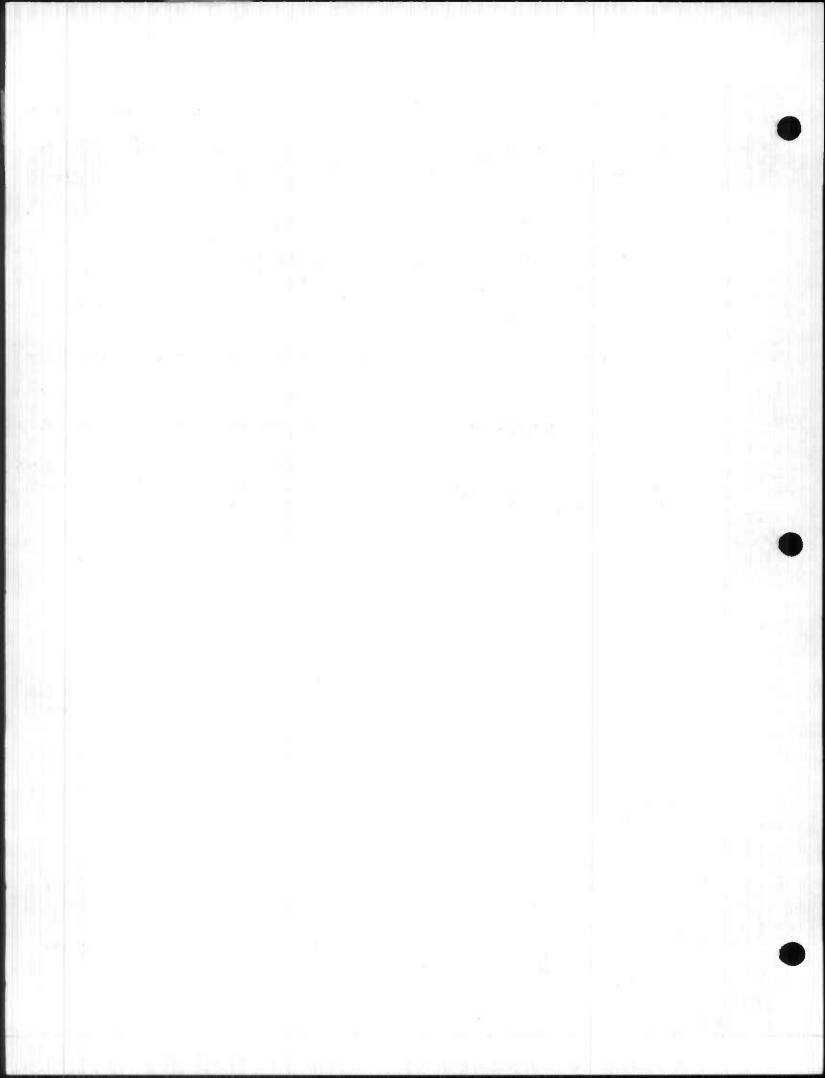
APR11

32. Registrar's Signature

Ave.

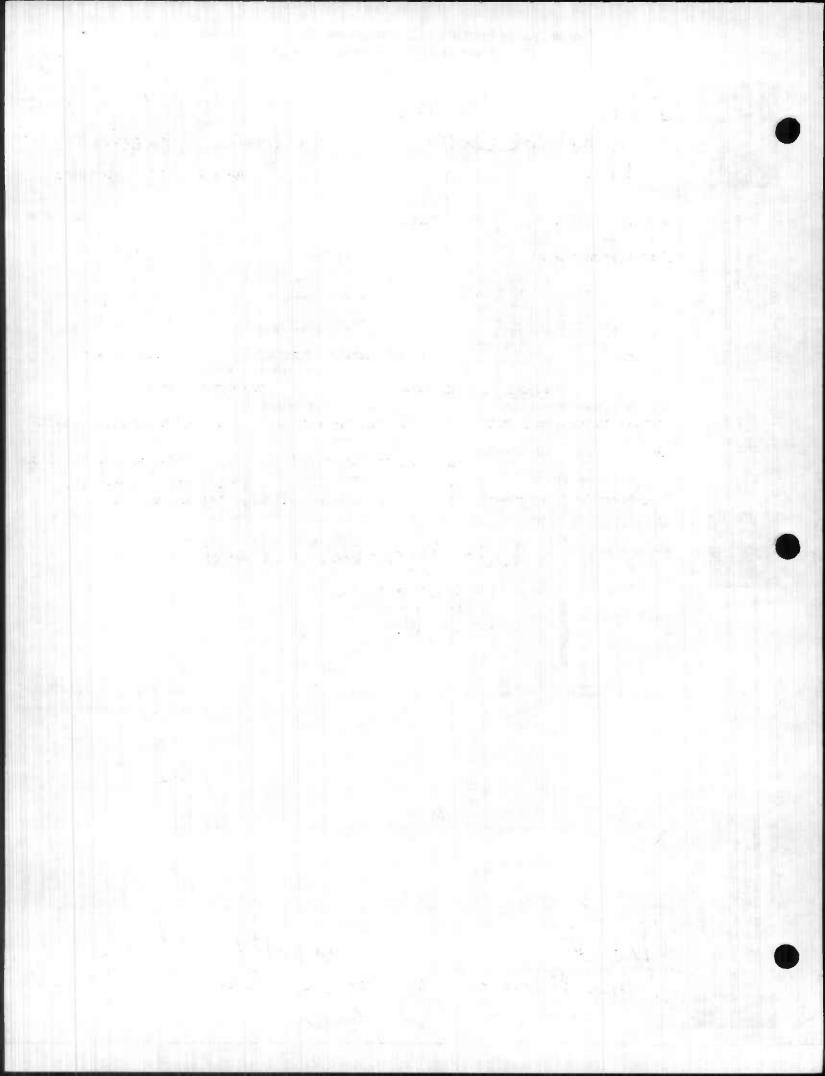
Balt, me

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Medical more 0 W If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year Birthplace (State or Foreign Country) . Age (In yrs. lest birthday) **Funeral** Months Days Hours 10 M 20 F 46 8890 215 June 3, 1944 Director Maryland Usuai Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or flams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1712 Sexton Street 21230 U.S. permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s Funeral 14. Race - American Indian, Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No ff Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede comp Elementery/Secondary (0-12) College (1-4or 5+) Label Machine Operator 12th Aerosol Plant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Catherine Swope August F. Seabrease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Valerie Seabrease / Wife 1712 Sexton Street Baltimore, Maryland 21230 other altimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition any injury or o 1 XBurlal 2 Cremation 3 DRemoval from State Glen Haven Memorial Park 4/7/00 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Gonce Funeral Home P.A. neroustr 4001 Ritchie Highway Baltimore, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervei Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physiclan and s the burial-trens Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last certificate be exec Physiclan/Medical Due to (or es e consequence of): Se 980 for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Records, P.O. NO 1 Yes 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? peen completion of cause of deeth? has 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2D ER/Outpatient 3 DOA 2 1 Yes 1 | Inpatient funeral Dete of Injury (Month, Dey 27. Manner of Deat 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 DeNetural 2 Accident 1 🗌 Yes 2 No death. or Attend efter death Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, streef, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 29a. Certifier (Check o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) Medical and manner stated. To the To the To the I 29b. 5/6 and the of car 29c. License number 29d. Date signed (Month, Day, Year) 30: Nam who completed cause of death (Item 23e) (Type, Print) 31. Date 32. Registrer's Signature State reper-a

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11700 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 C Schultz 1659 Clare 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth of Maryland System Haltmore Medical N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Months 010 18 0248 1□ M 2KDF 82 1917 Oct. 4, Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 7891 Mansion House Crossing 21122 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 212 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Technician 2 years Hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis McIntyre Emma Dufresme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7891 Mansion House Crossing Leona Schultz Daughter Pasadena, Maryland 20b. Place of Disposition (Name of cornetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 4/13/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 smerole 23d. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) surancoplastic Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Axonal Numpathe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Van 2 No 3 Probably 4 Unknown High Blood 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

sician and burial-transit The law requires that the death certificate be executed physician s the burlal P.O. Box 68760, USB BS Records, 60 page 2 Division of Vital this

Physician/Medical Examiner þ Completed Be Certification: To After

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

rail, or items 23a or 28s-f show Examiner must be notified at

Director

Funeral

by

Completed

Be

2

the Maryland

with 1

deeth

permit. Pagas 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If flam 27 is marked other than "natural", or hist any injury or other treumatic event, the Medical Emmin

**Physician** /Medical

Examiner

altimore, Maryland 21215-0020

or Attending Physician: after death. completely filled in by

DHMH 16 Ray 6/95

24 hours a Hospital

within 2 To the \$

> State Registrar

Medical

Vapessa 31. Date filed (Month, Day, Year) APR 1 1 2000

Villology Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 1 Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

29c. License number

28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

22 S. Greene Street

32. Registrar's Signature

1 Yes 2 No

5 Pending investigation

6 Could not be

27. Manner of Death

1 Matural

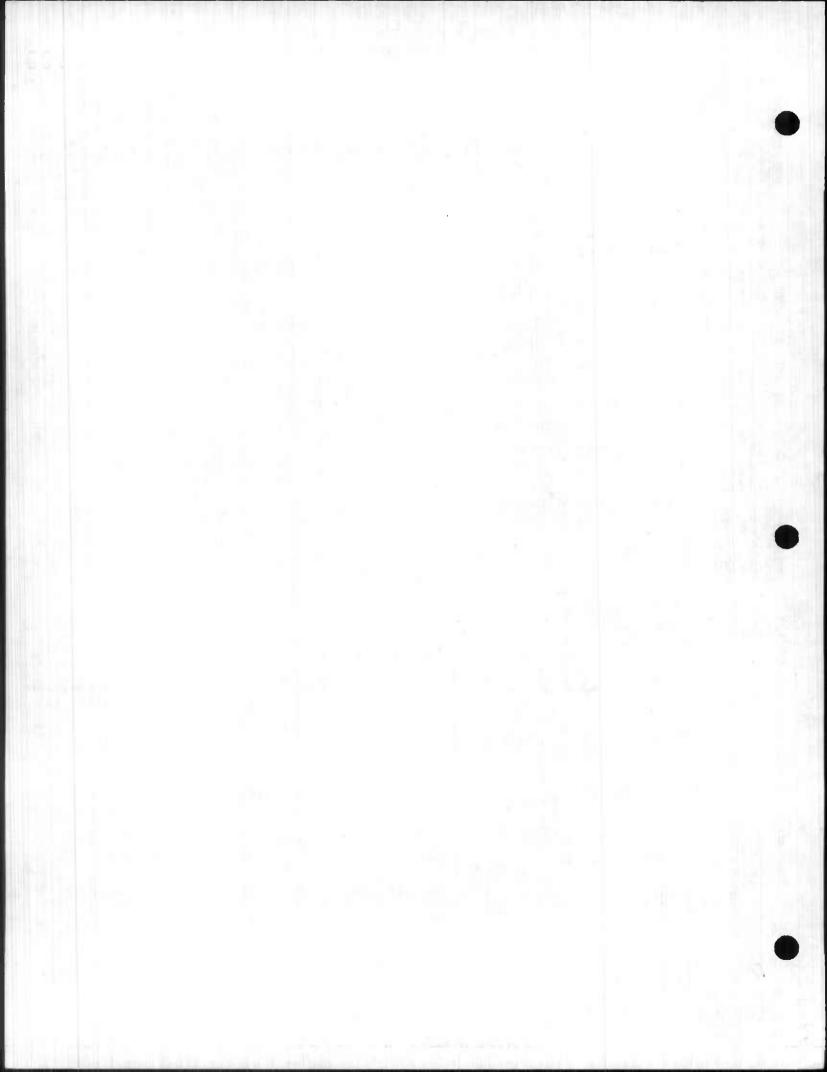
2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier



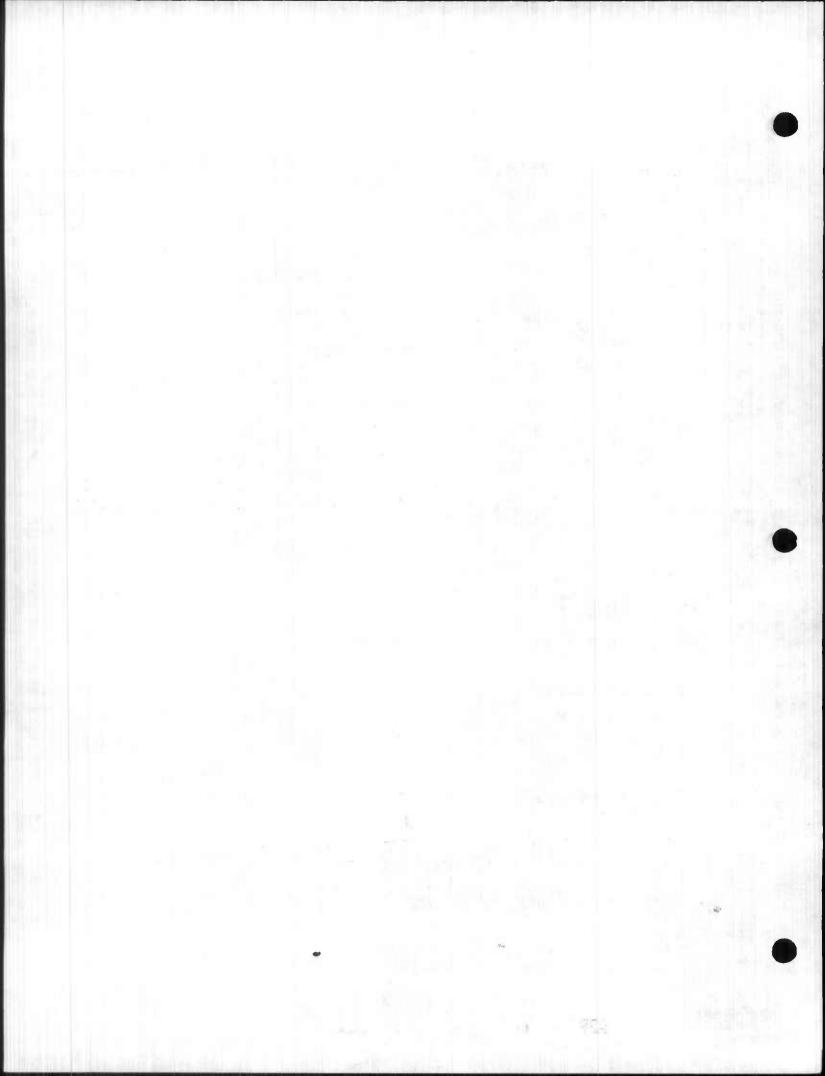
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#9 perFHG782 4/11/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** PEARL SEIDENBERG APRIL 2000 3:30AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, MAR. 29 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Months 1□M 2□F 1920 042-09-2071 80 NEW LONDON, CT. Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2√No BALTIMORE 289-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1701 POMONA DRIVE 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 Yes 2√2 No Specify: Specify:WHITE 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE MEDICINE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 HARRY KUSHNER LOTTIE RIBNER Pages 1 and 2 should 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Health of Health SUSAN TAPPER/ DAUGHTER 6 STONEHENGE CIRCLE #5, BALTIMORE, MD. 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State b 1 XBurial 2 Cremetion 3 Removel from Stete ARLINGTON-CHIZUK AMUNO 4 □ Donation 5 □ Other (Specify) 4/9/00 BALTIMORE, MD. 22. Name and Address of Facility 21 Signature of Funeral Service Licenses SOL LEVINSON & BROS. INC. B900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. **Physician** Congestive /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner CONDIPAY Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown of Vital Records, þ Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 28 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 Yes 25 No this funeral 28d. Describe how injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 TYes 2 No death 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 T Homicide or a To the Hospital within 24 hours a To the Funeral C ft☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 290. Signature and title of certifier uns 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Charle St. balto and 2120s GAMC 6201 31. Date filed (Month, Day, Year) 32. Registrac's Signeture

Registrar **DHMH 16 Rev 6/95** 

State

ain

**ORIGINAL** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day 9, April 2000 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Keswick Multi-Care Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 2 F Months Deys Hours 217-07-7351 Yrs Oct. 81 4,1918 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Pikesville 1 Yes 2XXX 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 219 McHenry Avenue 21208 USA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes ♣ No If Yes, Give Year or Detes: 1 Never Married 28 Merried 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11 Mechanic Trailors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Valentine Thompson Mary Wroblewski 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Thompson 219 McHenry Avenue Pikesville, MD 21208 Wife 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Meadowridge Mem. Pk. 4/14/00 4 ☐ Donation 5 ☐ Other (Specify) Dorsey, Maryland 21. Signeture of uneral Service Lio 22. Name end Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 hat caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting In death) Due to (or es a consequence Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 24 No 3 Probably 4 Unknown 24b. Were autopsy tindings evelleble prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 □ Yes 2 □ No 25. Was case referred to medical 26. Piece of Death (Check only one) 1 ☐ Yes No Other: Wursing Home 5 Pesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be

Examiner The law requires that the deeth certificate be executed the burial-transit pue Box 68760. Physician/Medical 189 esu be deteched for P.O. signed by Records, þ Completed has page 2 certificate Division of Vital spital or Attending Physicien: The hours efter death.

Ineral Director: After this certificate y filled in by the funeral director, pa Be P Medical Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

x 28a-f show show

6

"natural", or itema 23a or

The Medical

Pages 1 and 2 should be filed within nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than ' Iry or other traumatic event, ma Ma

Department of Important: If any injury or

**Physician** 

/Medical Examiner

Director

Funeral

by

Completed

Be

with the Maryland

death v

filed within 72 hours efter

21215-0020

Baltimore, Maryland

27. Manner of Deeth Natural 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a, Cartifier

🔹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

29b. Signature and the of certifie

fedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

ot death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year)

1 APR 1 2000



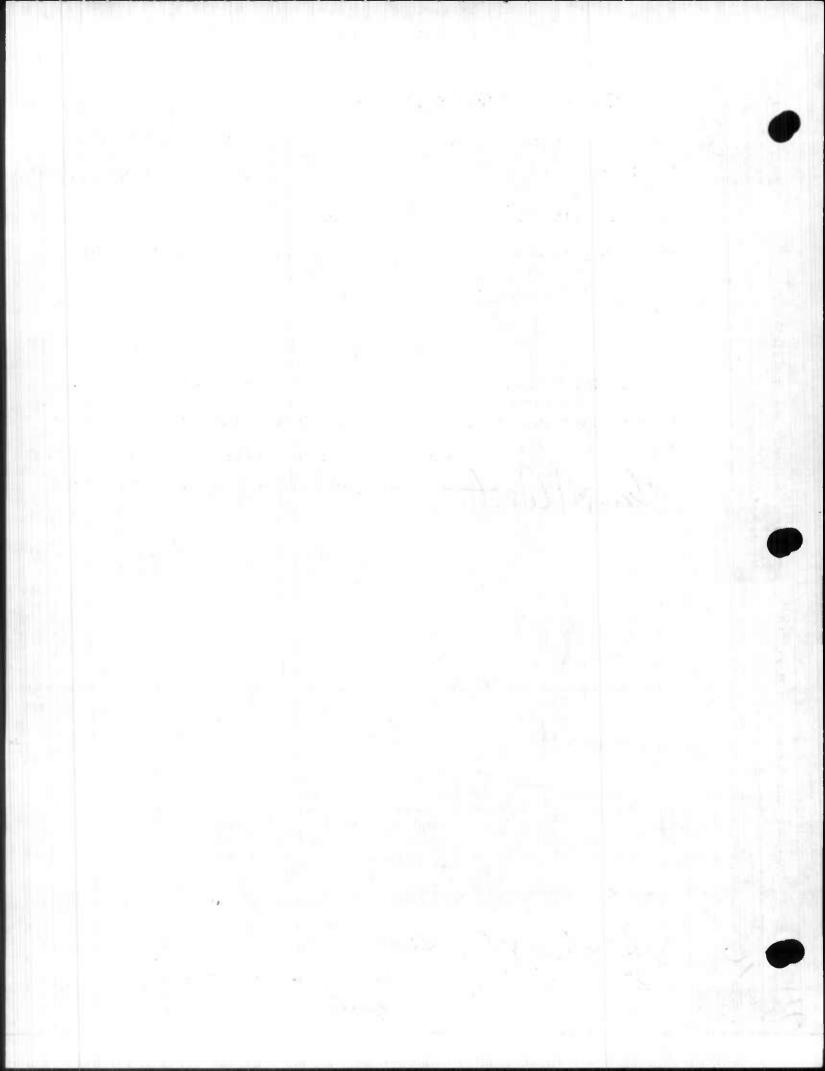
West 40- Street Baltino

**DHMH 16 Rav 6/95** 

State

Registrar

To the Hospital of within 24 hours of To the Funeral Discompletely filled in

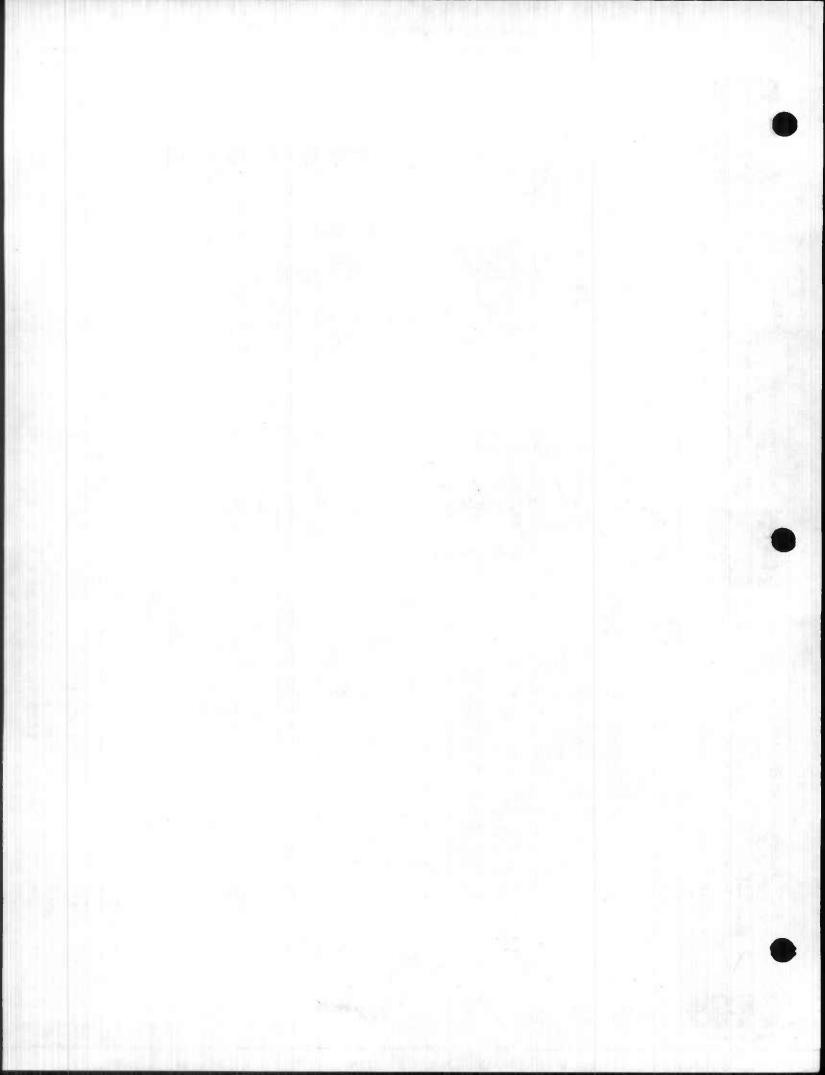


Certificate of Death

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Thomas Wann

	1. Decedent's Neme (First, Middle, La	st)				2. Deta of Deal		3. Time of Death		
Physician /Medical	Thomas	s N. Wa	ann			April	6, 200	00 11:25 AN		
Examiner	4a Fecility Neme (If not institution, giv	e street end number)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
	Stella Maris	Hospice			Towso	n	Ba:	ltimore		
Funeral Director	5. Social Security Number 6. S 212-36-1255	7. Age (In)	Yrs. lest birthdey) Yrs.	Months Deys		(Month, Dev.	Year) 5,1937	9. Birthpleca (Stete or Foreign Country) Maryland		
and Mental Hygiene.  and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-1 show raumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	Usuet Residence of Decedant	140-	01 T					1		
a how	Maryland N/A	10c.	Baltimo					10d. Inside City Limits XIXYas 2 □ No		
or 28a-f s be notified			Darcing			1.				
23a or 2	10e. Streef and Number 3027 Elm Aven	ue		10f. Zip Code	21211	1	hat Country? SA			
In line	11. Meritel Stetus	12. Wes Decedent Evar in Armed Forces?	n U,S. 13. W	as Decedent of Yes, specify Cut	Hispanic Origin? (	Specify Yes or No- rto Rican, etc.)		- American Indian, c. White, etc.		
Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	XXNever Merried 2 Married 3 Widowed 4 Divorcad	1 ☐ Yas 2 ▼No If Yes, Give Yaar or Dates:	11	□Yes 2√XX	Specify:		Specify: White			
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To Be	Edgar Wann,	Sr.			0	ssa Ward	E			
ma	19e. Informent's Neme/Ralationship (					Rural Route Number				
ar tr	Janice Chalk	Sister			Street		imore,			
8	20a. Method of Disposition  X⊠Burial 2 □ Crametion 3 □	Pernoval from State	<ul> <li>b. Plece of Disposi cemetery, crema</li> </ul>	ition (Name of atory or other pla	ace)	Data	20c. Location - (	City or Town, State		
nux	4 Donetion 5 Other (Specific		Lorrain	e Park	Cem.	4/10/00	Wood.	lawn, MD		
any in	21. Signeture of Funerel Sarvice Licen	(4)	- B		Henss-S			Home, Inc.		
	23a. Perit. Enter the disease, or companies shock, or heart failura. List only	plicetions that caused the d	eath. Do not enter	the mode of dy	IIS ROA ing, such es cardia	d Baltli	nore, i	MD 21211 Approximeta Interval Between		
in and inelanding the second s	rasulting in death)  Sequentially list conditions.	b	o (or as e consequ o (or es a consequ							
burial:	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last  Due to (or es a consequence of):  C.  Due to (or es a consequence of):									
attending physician and for usa as the bunal-transit clan/Medical Examir										
d for u	Pert It. Other significant conditions or	ontributing to death but not	rasulting in the und	deriving cause o	iven in Pert I.	23b. Did to	obacco use con	tributs to the causs of death?		
detached of Physic					1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unkn					
sata has been signed by the in page 2 should be detached Completed by Physic						24a. Wes a perform	n eutopsy med?	24b. Wara autopsy findings aveilable prior to completion of cause of death?		
rector, page	Section 1					1 🗆 Y	es 20 No	1 ☐ Yes 2 ☐ No		
Be Com	25. Was casa rafarred to medical				26. Place of De	eath (Check only on	ne)			
9 5	examiner? 1 ☐ Yas 2 📉 No	Hospitel: 1 ☐ Inpatient 2			or (Specify) HOSPICE					
65	27. Menner of Death  1 XNatural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Dey Year	28b. Time of Injury	28c. Inju		28d. Describe ho				
ed in by the funera Certification:	3 Suicide 8 Could not by determined	28e. Place of Injury - A building, atc. (Spe	t home, farm, stree ecity)	et, fectory, office		28f. Location (Si City or Town	treet end Numbi n, Steta)	er or Rural Route Number,		
completely filled in by the funer	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bast of my hiner: On the basis of exam	knowledga, daath d inetion and/or inve	occurred at tha t	ima, data and plac opinion, death occ	e, and due to tha courred at tha tima, d	ause(s) end ms ata and place, a	nner as stated. and dua to tha cause(s)		
2 %	29b. Signeture end title of certifier	end mennar steted.		29c. Licen	se number	2	9d. Data signed	(Month, Day, Year)		
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N N		47-		( )	43125		41	7(00		
Toth	)	Completed cause of death (	tam 23a) (Tune D		43125		91	7100		
within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:	30. Name and address of person who of DR. TARIQ MAHMOOD			rint)	CIMONIUM,	MD 2109		7100		



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Name (First, Middle, Last) 2. Dete of Daath 3. Time of Death **Physician** Month APRIL 4, 2000 7:05 AM /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ursing Center SW stminser rolo est 5. Social Sacurity Number If Under 1 Year If Undar 24 Hrs. Hours Min. Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) Sex 1□ M 2DF **Funeral** 8. Dete of Birth (Month, Day, Year) Days Director 175-18-7451 May 3, 1916 PA Usual Rasidance of Dacadent 10a Stata 10b Count 10c. City, Town or Location 28a-f show 10d, Insida City Limits the Medical Examiner must be notified at MD Carrol1 Director Westminister 1 Yes 2 No 10e, Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò or flerns 23a 1234 Washington Road death Funeral 21157 USA 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: p Specify: white 3 ☐ Widowed 4 1 Divorced "natural", Completed 15. Dacadent's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry (Specify only highast grada complated) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Item 27 Is marked other than any injury or other traumatic svent. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown food store 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surneme) Be unknown unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Westminister Nursing Center 1234 Washington Road Westminister MD 21157 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 16 X Other (Specify) in state ature of Ednaral Service Licansee Konald S. Wade 22. Nama and Address of Facility State Anatomy Board 655 W. Baltimore Street Director lace Baltimore, MD 21201 at1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, eck, or heart feilure. List only one cause on each line. Intarval Batween Onset and Death **Physician** Immadiata Causa (Final disaasa or condition resulting in deeth) /Medical oticemia Examiner Dua to (or as a consaquance of): requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Ceusa (Disease or injury that Initiated avants resulting In daath) Lest Dua to (or as a consequanca of): Box 68760. Physician/Medical the Dua to (or as a consequence of): P.O. Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2⊠ No 3 Probably 4 □ Unknown Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? or Attending Physician: The law ypertension 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes casa referred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Other: Transling Homa 5 Residence 6 Other (Specify) /s after dea... this 27. Menner of Death Natural 28a. Data of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred Division 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled Cartifliar (Check only one) Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date end placa, and dua to the ceusa(s) and mannar as steted. Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date end placa, and dua to the ceusa(s) and mannar as steted. Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date end placa, and dua to the ceusa(s) and mannar as steted. Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date end placa, and dua to the ceusa(s) and mannar as steted. Medicai 29b. Signatura and titla of certifian 29c. Licansa number 29d. Date signed (Month), Day, Year)

of daath (Item 23e) (Type, Print)

miD.

32. Registrar's Signature

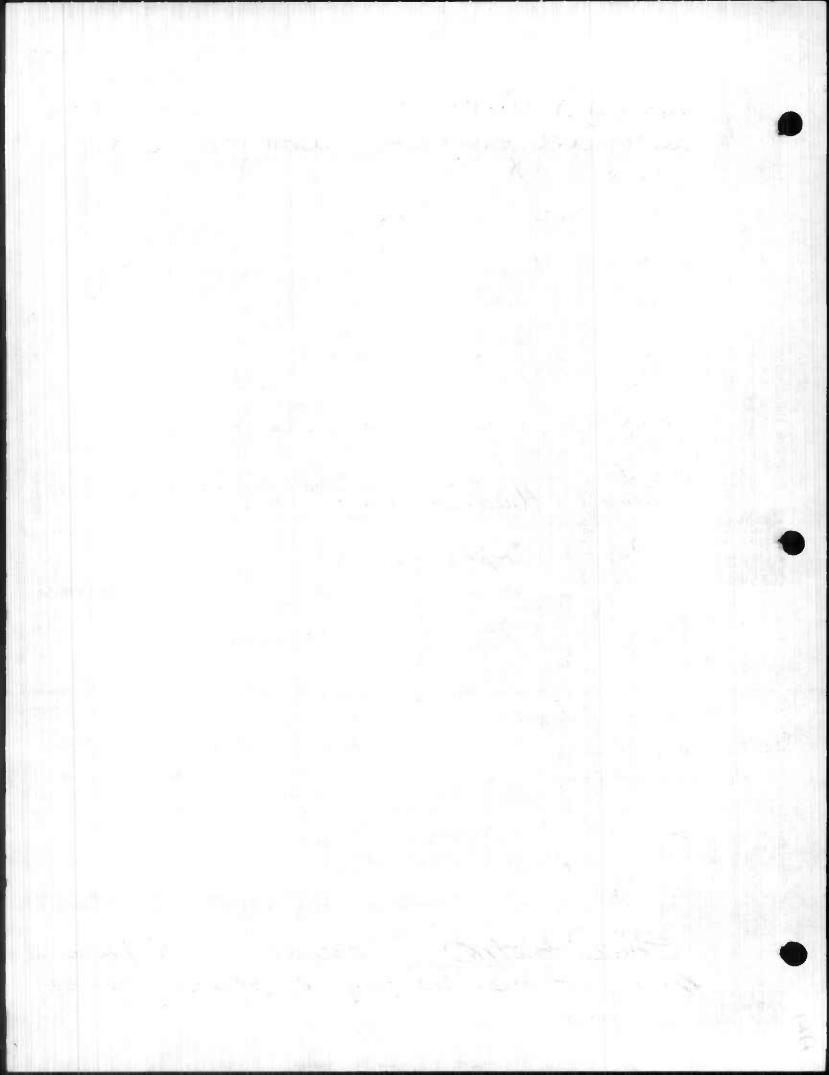
Washington Road, Westminster, Md 21157

Registrar
DHMH 16 Rev 6/95

30. Nama and address of person who completed causa

AUL E. FORST

31. Deta filad (Month, Day, Year)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11705 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month EDWARD WHITE 8:35 A.M M 9000 ord 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number If Under 1 05 e cla e Hospital C Baltimore anklin Square 6. Sex Birthplace (State or Foreign Country) Days 219-16-6832 15 M 2 F 74 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Apt.C Pine Branch Place 21221 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Merried 1 Yes 2 No Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Custodian EssexCommunityCollege 6th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcus White Leila Collette 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Baldwin / nephew 1752 Garden Ridge Road Gardendale Al 36071 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from Stete Metro Crematory Inc. 4/11/2000 Baltimore MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) 60-90Minutes monary graiomyopath Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): oronary Artery Dis Due to (or es a consequence of): n.D Atherosclerosis use given in Pert I. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the under 1)( Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Daeth (Check only one) Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28e. Dete of Injury (Month, Dev Year) 1 Netural 5 Pending 1 Yes 2 No investigation MARCH 23 2000 8130 PM 2 Accident TRIPPED OVER PARTleg 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 706 @ PINCBRANC 4 Homicide Essex Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

Examiner The law requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital or Attending Physician: this After 24 hours after death, Funeral Director: A Hospital within 2 94

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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**Physician** 

/Medical

Examiner

Completed by Physician/Medical

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DHMH 16 Rev 6/95

Registrar

2000

Dereng A. Klugh

29b. Signeture and title of certifier

31. Date filed (Month, Dey, Year)

30. Name end eddress of parson who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD 32. Registrer's Signeture

**ORIGINAL** 

29c. License numbe

29d. Date signed (Month, Day, Year)

2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Dey 4.9 Yaar **Physician** EANNETTE 1. VELL MARY 4-PRIL 2000 07 /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Examiner BAL 717 If Under 1 Year If Under 24 Hrs. HOSPITAL AGNES TIMORE 5. Social Security Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthdey) **Funeral** Days Months Hours 1 M 2 M F 218-22-5210 Yrs. Director 6,1927 MARYLAND Usual Residence of Decedent 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 Yes 2 No Director BALTIMORE MARYLAUD 10f. Zip Code 10a. Street and Number 10g Citizen of What Country? U.S.A. N. BRADDISH AVENUE Funeral fterns: 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, afc.) 14. Rece - Amarican Indian, Bleck, White, etc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Married 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Yeer or Defes: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) Collega (1-4or 5+) LONDON FOG SEAMSTRESS 12 TH GRADE altimore. Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Department of Health and Mental Important: If Itam 27 is marked of any injury or other traumatic ava TISSAC WELLS HENRIETTA MN-UNKNOWN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) INA PASTMORE (DAUGHTER) 860 MURFREES BORD PIKE APT. 5-16, NASHVILLE, TN 37217 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 Ø Cramation 3 ☐ Ramovel from State METRO CREMATORY 4 ☐ Donation 5 ☐ Othar (Specify) 04-10-00 21. Signature of Funaral Sarvice Licenter 22. Neme end Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** /Medical Immediata Causa (Final BACTERIAL SEVEN DAYS disaase or condition rasulting in daath) Examiner Physician/Medical Examiner SEPS15 SEVENI DAY Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): CANCER OF I WO MONTHS CELL Dua to (or as e consequence of) Part II. Other significant conditions contributing to death but not rasulting in tha undarlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Wara autopsy findings available prior to complation of ceusa of daath? Be Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificata or Attanding Physician: after death. Director: After this certifica funaral director, 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) edical Certification: To 1 Yas 2 No 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be determined To the Hospital or Atta within 24 hours after de To the Funeral Directo complately filled in by th 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, deta and place, and dua to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the tima, date and place, end due to the cause(s) and mannar stated. 29a. Certifier (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Dete filed (Month, Day, Year)

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SIMEON

OBENG, ST AGNES

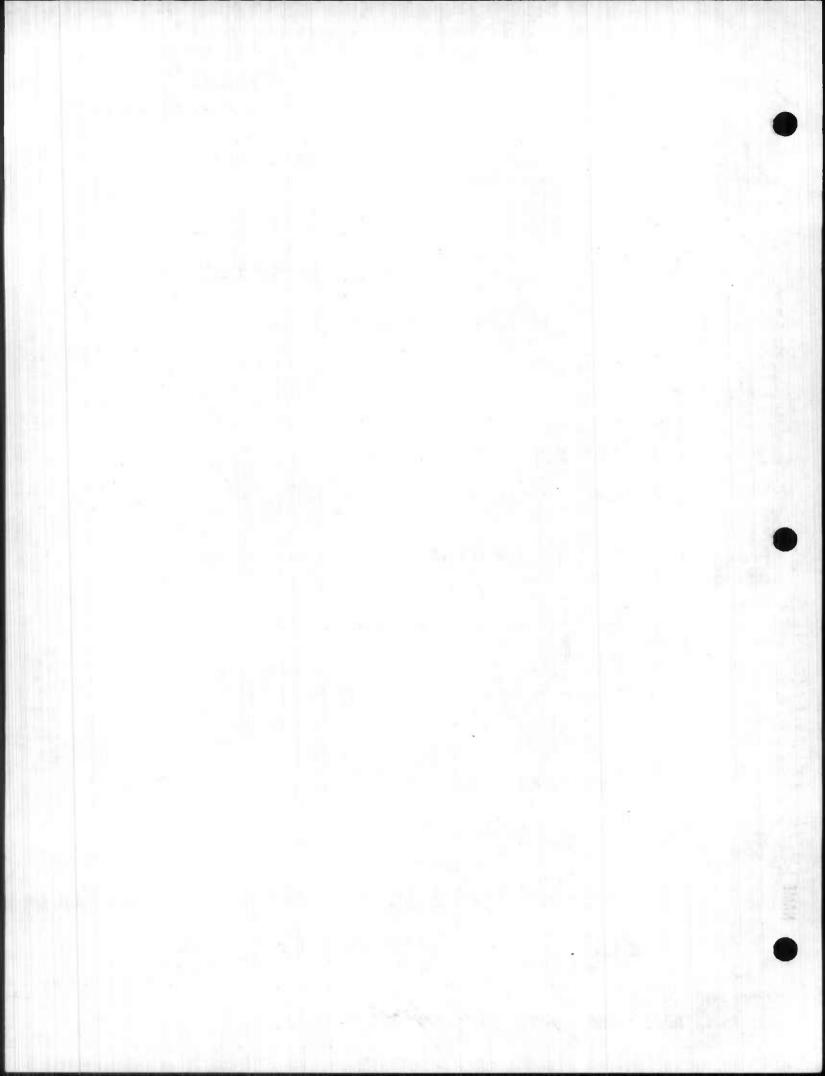
Ben G Spark

30. Nama and addrass of person who complated ceuse of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

APRIL 10, 2000

HOSPITAL, 900 CATOM AVE. BALTIMORE



### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Physician 2500 IAMS 12:00 P.M. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAL7 If Under 24 Hrs. AVENUE IHORE If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign ,Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 KF 214-30-426 Yrs. IRGINIA Director Usual Residence of Decede 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow must be nothled at 1 Yas 2 □ No MARILAND Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò AVENUE SA Items 23a URDUE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, 11 Merital Status Black, White, etc. traumatic event, the Medical Examiner 1 Never Merried 2 Merried ò 1 Yes 25 No Specify þ 3 Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within ) Department of Health and Mental Hygiene. Important: If then 27 is marked other than "na any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 5 TH GRADE UNION MEMORIAL HOSP. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be TONES AVLOR HENR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) FLORENCE ENGLISH (DAUGHER) PURDUE AVENUE BALTIHORE, MD - 21239 20c. Location - City of Town, State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removel from Stete ARBUTUS CEMETERY 4 □ Donation 5 □ Other (Specify) 04-13-00 BALTIMORE, MARYLAND 22. Name and Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME 2 140 N. FULTON AVE., BALTIMORE, MD. 2121 Approximate 21. Signature of Funeral Service Ligenses 2 BALTIHORE, MD. 21211 23a. Peh1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical 24hr SEPTILEWIA Examiner Due to (or as e consequence of): refui. Examiner CATKIER Hemo Diamisis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as e consequence of): physician 51466 REHAL DX. Physician/Medical that initieted events resulting in death) Last the Due to (or as e consequence of): US0 88 DI 472 TSS mé utine. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hemo die P 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed After this certificate has 1 Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Netural funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) 4 ☐ Homicide

The lew requires that the deeth certificate be executed Box 68760, P.O. of Vital Records, Physician: Division or Attending s effer de-ei Director: After filled in by To the Hospital o within 24 hours of To the Funerel Di completely

filed within 72 hours efter

21215-0020

Maryland

Baitimore,

State Registrar

DHMH 16 Rev 6/95

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

LSIKINLE KOPA (MS), 2. HAM 31. Date filed (Month, Day, Year)

LBIKUNLE

2000

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrer'e Signeture

Kola

2. HAmice

m. 1)

29c. License number

D42219.

No

**ORIGINAL** 

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

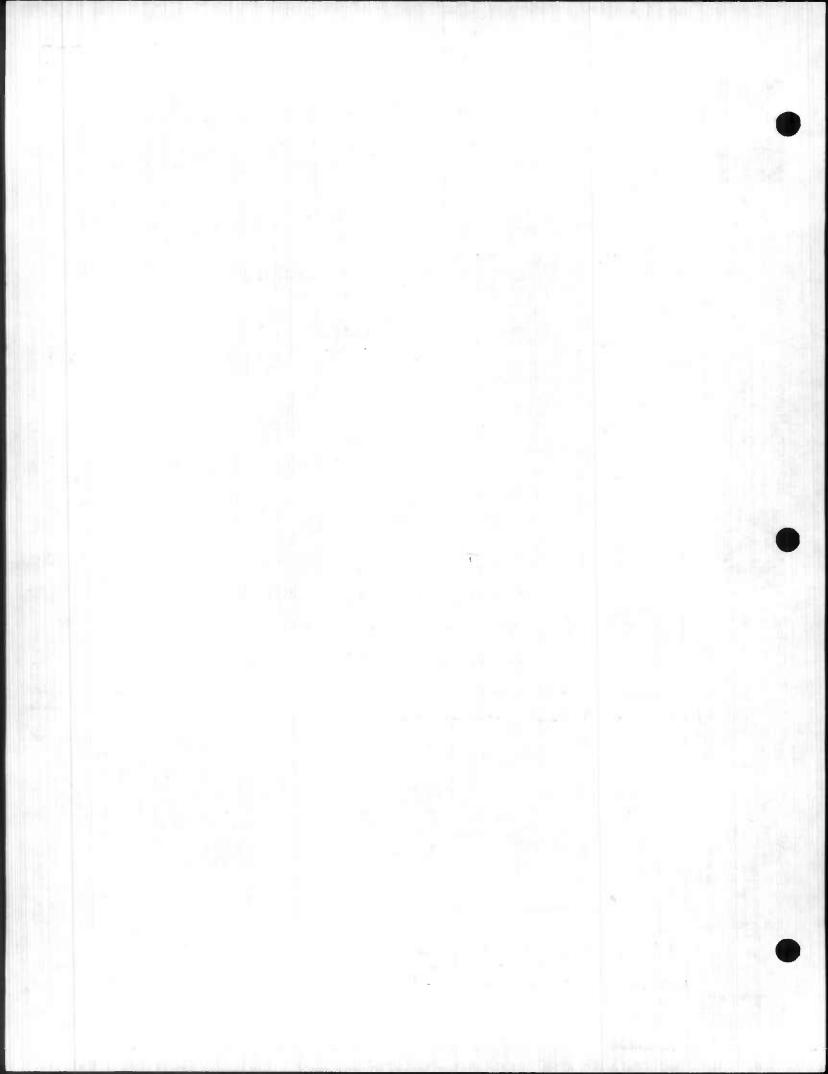
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year)

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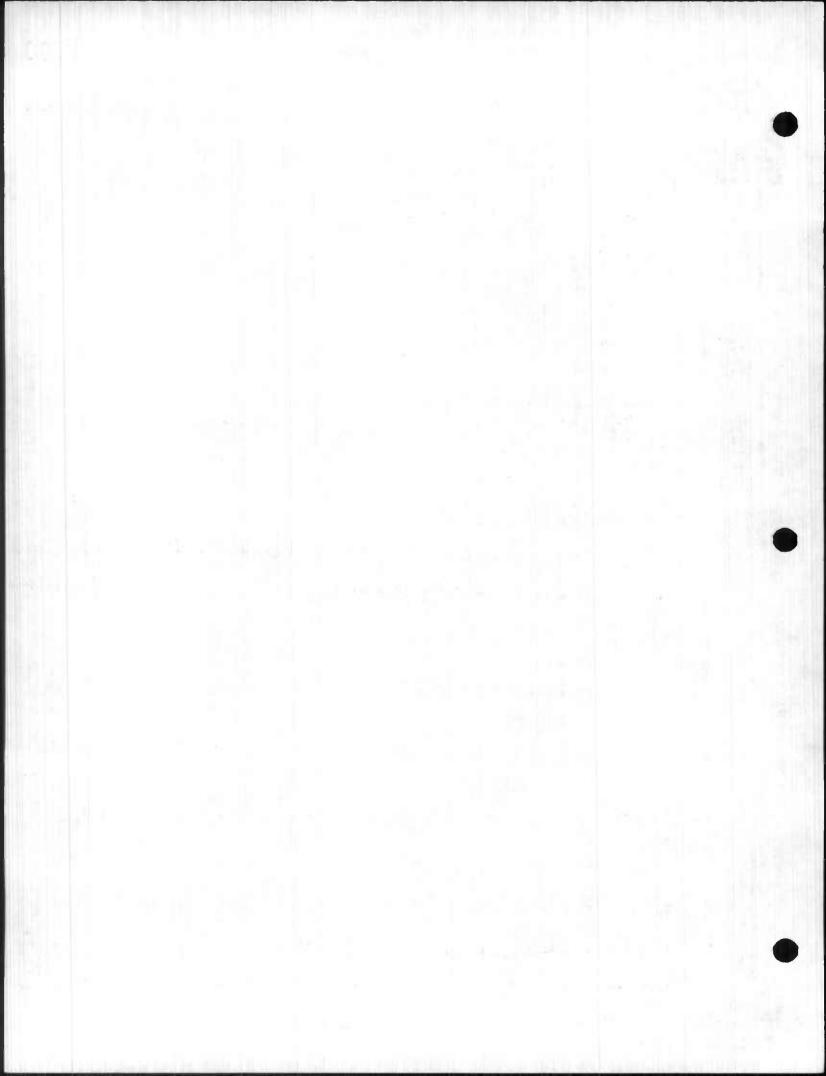
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Examiner	4e Facility Name (If not institution, give						n, or Location of Dec	eth 4c. Count	y of Deeth		
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Funeral Director	213 07 7431	DM OFF	yrs. last bir	Yrs. Month	der 1 Yaar s Days	Hours	Min. 8. Date of E (Month, I July 1	Dey, Year) , 1919		place (Stete or Foreign ntry) ryland	
show dat	Usuet Residence of Decedent  10a. State 10b. County			n or Location					1	10d. Inside City Limits	
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23s or 3 unit be n	10e. Street and Number 209 Meadow Road	1122		10g. Citizen of Whet Country? U•S•							
020 our after death very aff, or terms 23 Examiner mast by Furneral	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Detes:W • V				Hispanic Originan, Mexican, I	n? (Specify Yes or I Puerto Rican, etc.)	14. Ra Bla Specil	ck, White,	can Indien, etc. nite	
5-0-572 hourself and all seal a	15. Decedent's Ed (Specify only highest grad	16e.	Give kind of work done during most of working  life. DO NOT use retired)						dustry		
1 21215-0020 ad within 72 hours at agreement than "natural", or it, the Medical Exam Completed by F	Elementery/Secondery (0-12) 12th		life. DO NOT Electro				Wes	tingh	ouse		
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Saltimore semit. Pages 1: Suparment of He montant: if item my Injury or other not injury or other	20e. Method of Disposition 1⊠ Buriel 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Ramoval from Stete	cemeter	Disposition (A y, cremetory o	r other ple		Date 4/13/00	20c. Location Baltim		own, Stete Maryland	
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/ /Medical Examiner	Immediete Cause (Finel diseese or condition resulting in deeth)	. Acut		Mye		4 6	enker	nia		9 Month	
Je Je		Med	to (or es e	consequè de c	1): 1 a					9 Month	
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(OX)	30. Nama and address of person who c	ompleted cause of deeth	(Item 23a) (		in	fure	#602	Glen A	sur	,2000 nie MD. 21061	
State	31. Dete filed (Month, Dey, Year)	32. Registrar's S		4			1			21001	

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

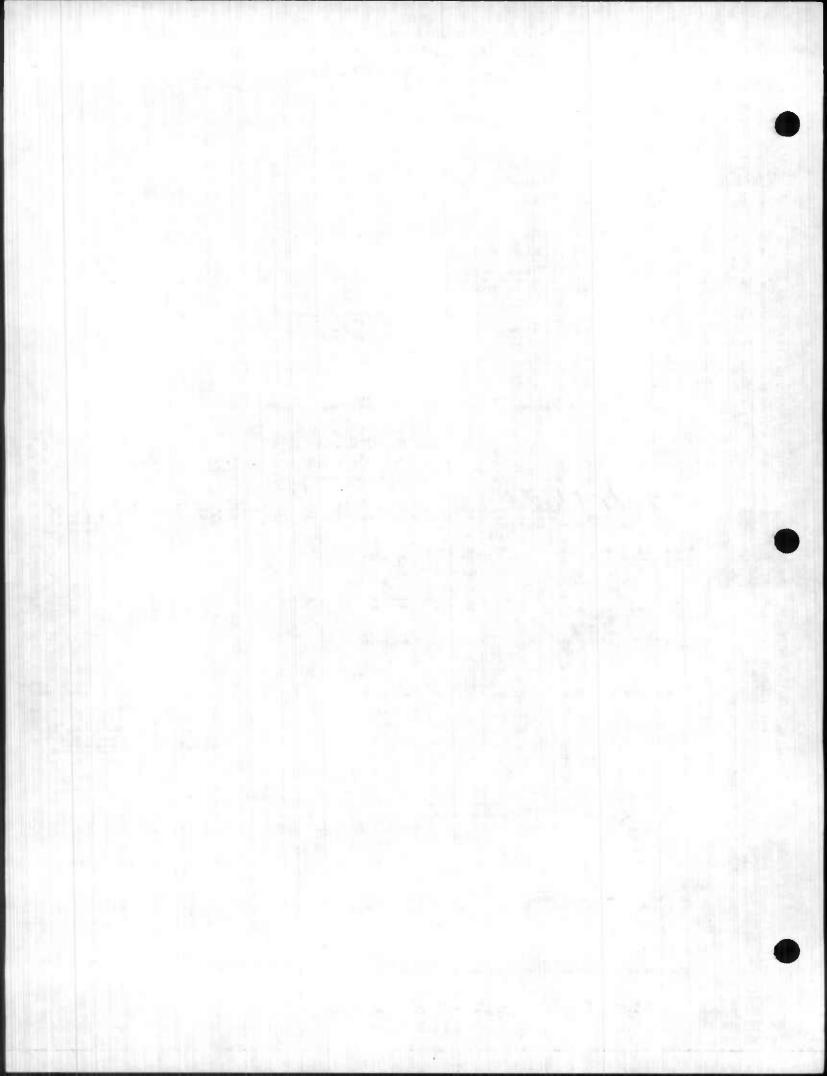
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Year **Physician** Jennie York April 06, 2000 6:15am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Howard County General Hospital Columbia Howard # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 02-19-07 5. Social Security Number 7. Age (In yrs. last birthday) Months Birthplace (State or Foreign Country) **Funeral** 1□M 2/ F Yrs. 93 432-36-3512 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28s-f show the Medical Examiner must be notified at Anne Arundel Glen Burnie 1 Yes 20No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21060 101 Cherry Lane USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. flied within 72 hours efter 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade NA Laborer Sewing Industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other traumatic event pages. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) 8 Belle Woods Mose Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Cherry Lane Glen Burnie, MD. 21060 Marie Hardy 20c. Location - City or Town, Stete MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date X Burial 2 ☐ Cremation 3 ☐ Removel from Stale 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 04-12-2000 Anne Arundel Co, 22. Name and Address of Facility 21. Signature of Funeral Service Licens Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart lattire. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 10045 KIDNEY FAILURE Examiner Due to (or as a consequence of): Examiner 9 Days GAN BRENE OF FOOT physician and a the burlet-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed page 2 1 P. 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Attending Physician: 25. Wes case referred to medical axaminer?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? Affer 1 Blatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: A 1 in by the f in 24 hours.
The Funeral Director filled in by the 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital edicai 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier D17502 Tiens 2 Geyser MD APRIL 7, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 LAURE PARIS DRIVES SUITE 102 A LAUREL MD 20707

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Leave & Spork



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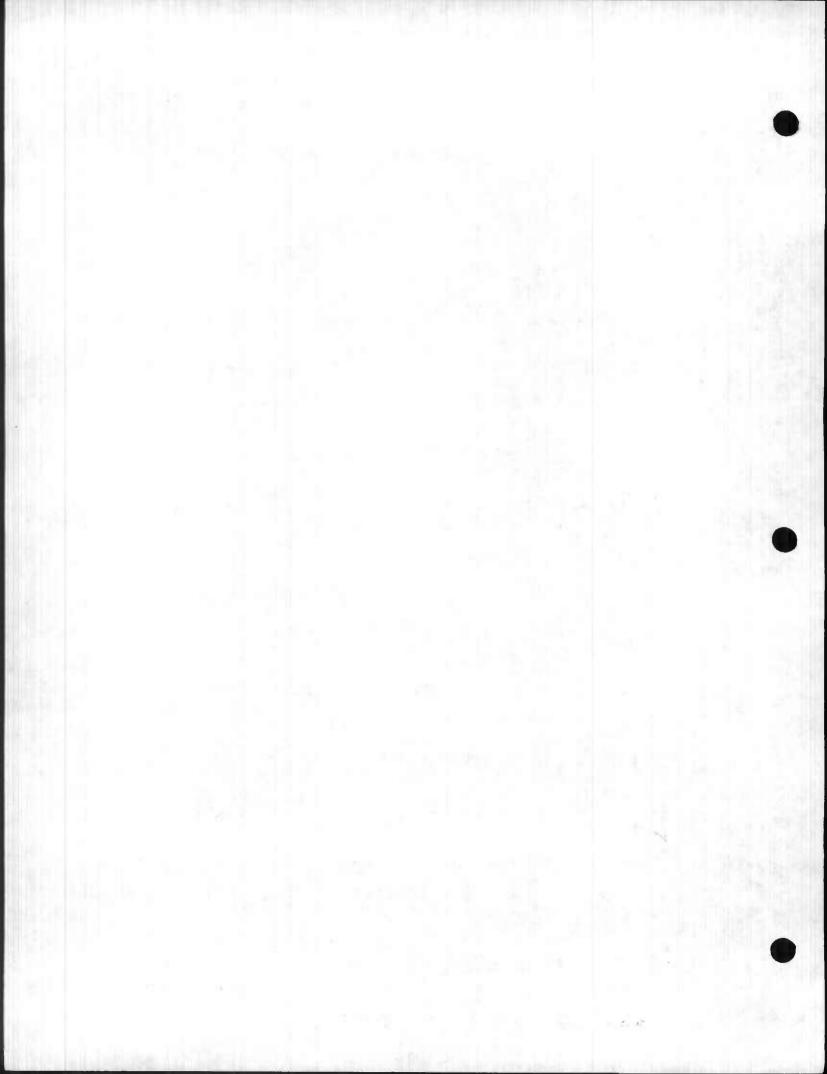
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day 2000 Month **Physician** 5 ARNOLD YOUNTS JR APRIL 5:55am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** 5 Brett Court Essex Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Oct 28 9. Birthplaca (State or Foreign 5. Social Security Number **Funeral** 1₩ M 2□ F Days 212-32-9422 MAryland Yrs. 64 Director Usual Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Md. Baltimore Essex 1 ☐ Yes 2€ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Brett Court 21221 USA natural, or items 23s. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify. White If Yes, Give "' Year or Datas: ğ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Maryland Dry-Dock Blacksmith. 8th permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important; if flem 27 is merived other any fnjury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arnold J. Younts Sr. Maud A Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Brett Court Baltimore Md. 21221 Nadine S. Younts /wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4/7/2000 Metro Crematory Inc. Baltimore Md. 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licanus 22. Name end Address of Facility Connelly Funeral Home of Essex 23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Bet Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical ingestive **Examiner** Due to (or es a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attanding physician for usa as the buria Box 68760 +16V certificata be Physician/Medical Dua to (or as a consequence of) 88 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Probably 4 Unknown yd bengis Division of Vital Records. b 8 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Deen performed' certificata has 1□Yes 20No 1 Yes 2 No 25. Was case referred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No To After this 27. Manner of Death 1 De Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier norm 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) 1245 Eastern Blud Center Middlesex Health

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signetura



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 24, 2000 M. March 1:30 PM. Lora Young /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5101 River Road # 1714 Bethesda Montgomery If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Dev. Year) **Funeral** Hours Months Deys 1□M 2□F 75 Director 214-30-0714 Feb. 12, 1925 Germany Usual Residence of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director Maryland | Montgomery Bethesda 10e, Street and Number 10f. Zin Code 10g. Citizan of What Country? maint be 5101 River Road #1714 20816 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Give 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Never Merried 2 N Married Specify: White 1 ☐ Yas 2 ♥ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Etamantary/Secondary (0-12) Collega (1-4or 5+) Nurse - Office Manager 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be 10 Otto Attinger Sofie ( Unknown ) 19a, Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) mportant: If Item 27 my Injury or other tr Michael Young - Son 10206 Baltusrol Court, Oakton, Va. 22124 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 🖾 Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) 4/6/2000 Falls Church, Va. National Crematory 22. Nama and Address of Facility Joseph Gawler's Sons, Inc. 21. Signatura of Funaral Sarvice Licensee Combaker 5130 Wisc. Ave. NW., Washington, D.C. 20016 homas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvat Batween Onset and Death Physiclan /Medical Immediata Causa (Finat disaasa or condition rasulting in death) a. Acute Renal Failure 3 Days Examiner Dua to (or as a consequanca of): Examiner Bowel Obstruction 2 Months Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or Injury that initieted events rasulting In death) Last Dua to (or es e consequença of) Volumne Depletion Physician/Medical Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 Yes 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida edical 29e. Certifiar 1 Certifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital or Attending Physician:

the Maryland

filed within 72 hours after

Pages 1 and 2 should be Health and Mental am 27 ls marked o

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After

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24 hours after deat Puneral Director:

To the To the F

Hospital

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(Check only one)

29b. Signetura and titla of cartifier

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Baltimore, Maryland 21215-0020

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'natural', or

Hygiene.

**DHMH 16 Rev 6/95** 

State Registrar

Karl Eric De Jonge, MD. 110 Irving St. NW. #2b39, Washington, D.C. 20010-0218 31. Dete filed (Month, Day, Year) APR 1 1 32. Redistrar's Signatura

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

truc

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD20969

29d. Date signed (Month, Day, Year)

April 5, 2000

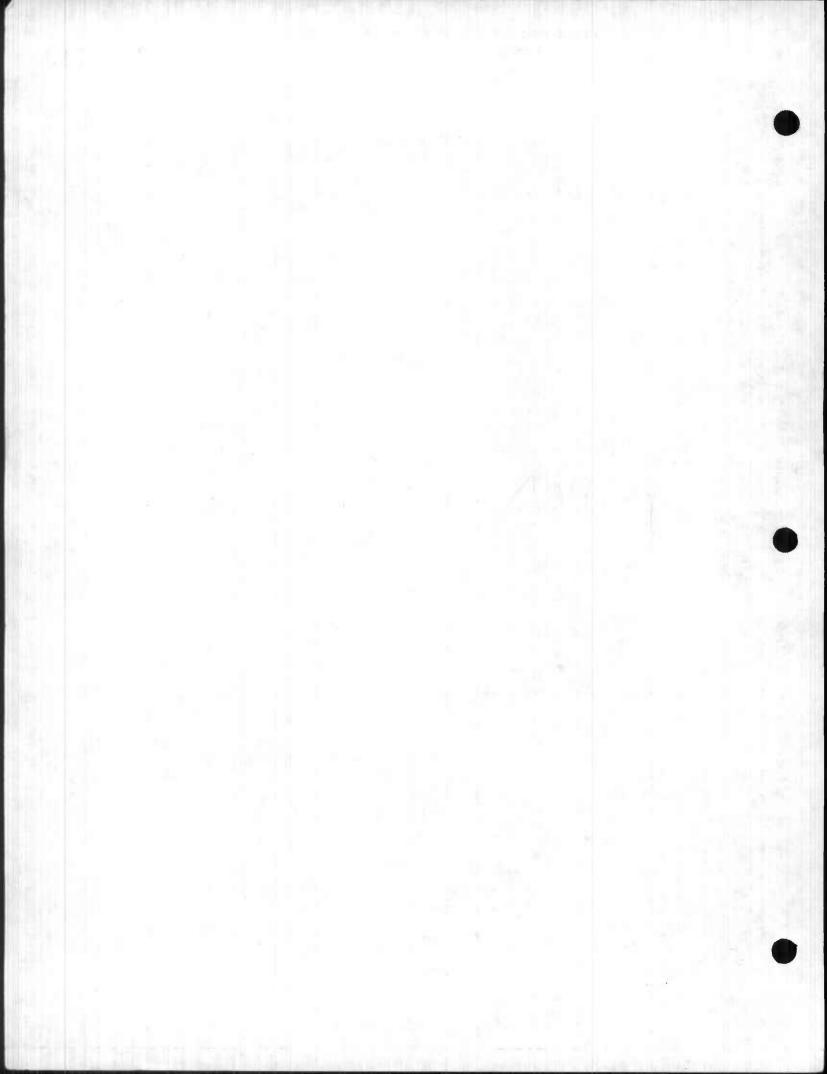
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State of Maryland / Department of Health and Mental Hygiene 00 11713

1. Decedent's Name (First, Middle, Lat Mildred Lee Ander 4a Facility Name (If not institution, give Charles County Nu: 5. Sociel Security Number 6. S 578-03-0621  Usuel Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Streel and Number 11216 Rock Road  11. Merital Status  1 Never Merried 2 Merried 3 Middle Mild Mild Merital Status	son e street end number) rsing & Re sex M 200 F	(In yrs. last bir 85 10c. City, Tow	Yrs. If U		La P1	ata  4 Hrs. Min.  B. Date of (Month,	Day h 25, 200 eeth 4c. Count Char1 Birth Dey, Yeer)	Year 3. Time of 8:45 by of Death  See County  9. Birthplace (State of County)			
4a Facility Name (If not institution, given Charles County Nu: 5. Sociel Security Number 6. S 578-03-0621  Usuel Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Streel and Number 11216 Rock Road 11. Merital Status 1 Never Merried 2 Merried	estreet end number) rsing & Re ex 7. Age	(In yrs. last bir 85 10c. City, Tow	Yrs. If U	Under 1 Year	La P1	March m, or Location of Do ata  Hrs. B. Date of Min. (Month,	eeth 4c. Count Charl Birth Dey, Yeer)	00 8:45 by of Death			
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1 Never Merried 2 Merried	11216 Rock Road 20852						United	States			
	12. Wes Decedent E	ver in U,S.	13. Was D	Decedent of H	lispanic Origi	In? (Specify Yes or		ce - American Indien,			
3 ⊠ Widowed 4 □ Divorced	Armed Forces?	lo	-			Puerto Rican, etc.)		ack, White, etc.			
	If Yes, Give Year or Dates:		1 U Y	es ZK No	Specify:		Specia	White			
	15. Decedent's Education		. Decedent's	Usual Occup	pation		16b. Kind of B	Business/Industry			
(Specify only highest gra	College (1-4or 5			(Give kind of work done during most of workillife. DO NOT use retired)			1				
10	College (1-401 5		memake	nemaker			Own Ho	ime			
17. Father's Name (First, Middle, Last)					18. Mother	a Name (First, Mid					
Richard Edward Se	ek				Maro	aret Rel	le Puch				
		19h	. Meiling Ad	idress (Street				n. Stete. Zip Code)			
	Daugnter										
	Removal from Stete							City of Town, State			
4 ☐ Donation 5 ☐ Other (Specify	y)	Parklaw	m Memor	rial Pa	rk	2000		lle, Maryla			
Immediate Cause (Final	plications that caused one cause on each lin	the death. Do	not enier the	Bet mode of dyl	hesda,	Maryland	1 20814-3	Approximat Interval Bet Onset and			
disease or condition resulting in deeth)								1			
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	D			- 23				1			
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Cause (Disease of Injury											
resulting in death) Last		Due to (or as a consequence of):									
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Part II. Other significant conditions of	ontributing to death bu	it not resulting in	n the underly	ying cause gi	ven in Part f.	23b. I	Did tobacco uae co	ontribute to the cause			
						1	I□Yes 2⊠No	3 Probably 4			
								T 045 W			
								24b. Were autopsy eveileble prior i completion of c			
						7		of death?			
						1	☐ Yes 2 🖾 No	1 ☐ Yes 2 ☐			
25. Wes case referred to medical					26. Place	of Death (Check or	nly one)				
examiner? 1 ☐ Yes 2 ☒ No	Hospitel:	nt 2 TER/Ou	utpatient 3	DOA OI	her: 4KJ Nur	sing Home 5□F	Residence 6 DOt	ther (Specify)			
27. Manner of Death	28a. Dete of Injur	y 28b.		28c. Inju	ry at	28d. Descr	ibe how injury occu	urred			
la cantingtion	(Month, Dey Year) Injury Work?					lo					
3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, ferm, street, factory, office 28f. Locat						ion (Street end Number or Rural Route Number				
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(Check only 2 Medical Exam	niner: On the basis of	examination an									
	and manner sta	ted.		20c Licen	sa number		20d Date sign	and Month Day Veer			
250. Signature and true of Certifie	2 1 milk	I Im	7	100			250. Date sign	os promi, boy, real)			
/W/ /4./\ /	- I WING	D21031					March 27, 2000				
Murail C	-			D	21031		March	27, 2000			
30. Name and address of person who	0	eeth (Item 23a)	(Type, Print)		21031		March	27, 2000			
F F	10  17. Father'a Name (First, Middle, Last) Richard Edward Set  19a. Informant's Name/Reletionship ( June M. Matteson/  20a. Method of Disposition  1	10  17. Father'a Name (First, Middle, Last)  Richard Edward Seek  19a. Informant's Name/Reletionship (Type, Print)  June M. Matteson/ Daughter  20a. Method of Disposition  1  Burial 2  Cremetion 3  Removal from State 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Liberary  21. Signature of Funeral Service Liberary  MO  23a. Fant First In disease or complications that caused habit feilure. List only one cause on each lin  Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated evenis resulting in death) Last  25. Wes case referred to medical examiner?  1  Yes 2  No  27. Manner of Death 1  Natural sequence of Pending Investigation 3  Suicide 1  Could not be determined learnined 29a. Certifier (Check only one)  1  Certifying Physician: To the best of and manner state.	10	Homemaki   First, Middle, Last   Richard Edward Seek     19a. Informant's Name/Reletionship (Type, Print)   19b. Meiling Ad     19b. Meiling Ad   11216   120c   120c   1216   1216   120c   120c   1216	10	17. Father's Name (First, Middle, Last)  18. Mother' Richard Edward Seek  19a. Informant's Name/Reletionship (Type, Print)  19une M. Matteson / Daughter  20a. Method of Disposition 12 Burial 2   Cremetion 3   Removal from Stete 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licenses  22. Name and Address of Facility Bethesda - Chevy C Bethesda,  23a. Part   Interine disease, or complications that caused the death. Do not enter the mode of dying, such as a consequence of the conditions or complications that caused the death. Do not enter the mode of dying, such as a consequence of the conditions or complications that caused the death. Do not enter the mode of dying, such as a consequence of the conditions or condition resulting in death)  25. Wes case referred to medical examiner?  26. Place of Disposition (Meme of cameter) Park (Interine disease or condition resulting in death)  27. Aspiration Pneumonia  28. Congestive Heart Failure  29. Due to (or as a consequence of):  29. Aspiration Pneumonia   Due to (or as a consequence of):  29. Aspiration Pneumonia   Due to (or as a consequence of):  29. Aspiration Pneumonia   Due to (or as a consequence of):  29. Aspiration Pneumonia   Due to (or as a consequence of):  20. Aspiration Pneumonia   Due to (or as a consequence of):  20. Aspiration Pneumonia   Due to (or as a consequence of):  20. Aspiration Pneumonia   Due to (or as a consequence of):  20. Aspiration Pneumonia   Due to (or as a consequence of):  20. Aspiration Pneumonia   Due to (or as a consequence of):  22. Acrification Pneumonia   Due to (or as a consequence of):  23. Aspiration Pneumonia   Due to (or as a consequence of):  24. Aspiration Pneumonia   Due to (or as a consequence of):  25. Wes case referred to medical examiner  26. Place of Injury At home, ferm, street, factory, office building, etc. (Specify)  27. Medical Examiner: To the best of my knowledge, deeth occurred et the time, dete end (Chack conty of the pression of the pression of the pression of the pression of the pressi	17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Mother's Name (First, Middle, Name of Carefully Name of Care	10			

DHMH 16 Rev 6/95



### Piease Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death March 27,2000 TRANCIS AVEdiKiAN 4:30 PM 4e Facility Neme (If not Institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Death Silver SPring Holy Cross Hospital Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 27, 1914 Birthplace (State or Foreign Country) Days Hours Months 1⊠M 2□ F Yrs. 115-09-2707 86 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d foside City Limits Maryland Montgomery Chevy Chase 1⊠ Yes 2□ No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 8100 Connecticut Avenue #511 20815 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Yes 2□No 42-1 Never Merried 2 Merried white 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) supervisor for plate making 12 U.S. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumerne) Avedis Avedikian Takouhy Derderian 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth B. Avedikian/wife 8100 Conn. Ave., #511, Chevy Chase, MD. 20815 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from Stete Mar. 30,00 Alexandria, Va. 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 22. Name end Address of Fecility DeVol Funeral Home 21. Signature of Funerel Service Licensee 2222 Wisconsin Ave., N.W., Wash., DC 20007 nter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, rheert feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Emply sema Due to (or es e consequence of): prostrate carcer Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2 XNo 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of fnjury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 1 Neturel 5 Pending investigation

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

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iermit. Pages 1 and 2 should be filed within 72 hours after Deperment of Healin and Mental Hygiene. Percentant if item 27 is restricted other than "netural", or its mylylury or other traumetic event, the Medical Example

altimore, Maryland 21215-0020

Director

Funeral

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Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit and physician **USB BS** signed by the at d be detached for Completed by peeu hes page 2 certificate Hospital or Attending Physician: funeral director, Be edical Certification: To this After death. after death

P.O. Box 68760,

Division of Vital Records.

25. Was case referred to medical exeminer?

6 Could not be determined

28c. fnjury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1607

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signeture and title of certifier

29e. Certifier

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Kathleen McShane, M.D., 1500 Forest Glen Road, SIlver Spring, MD. 20910

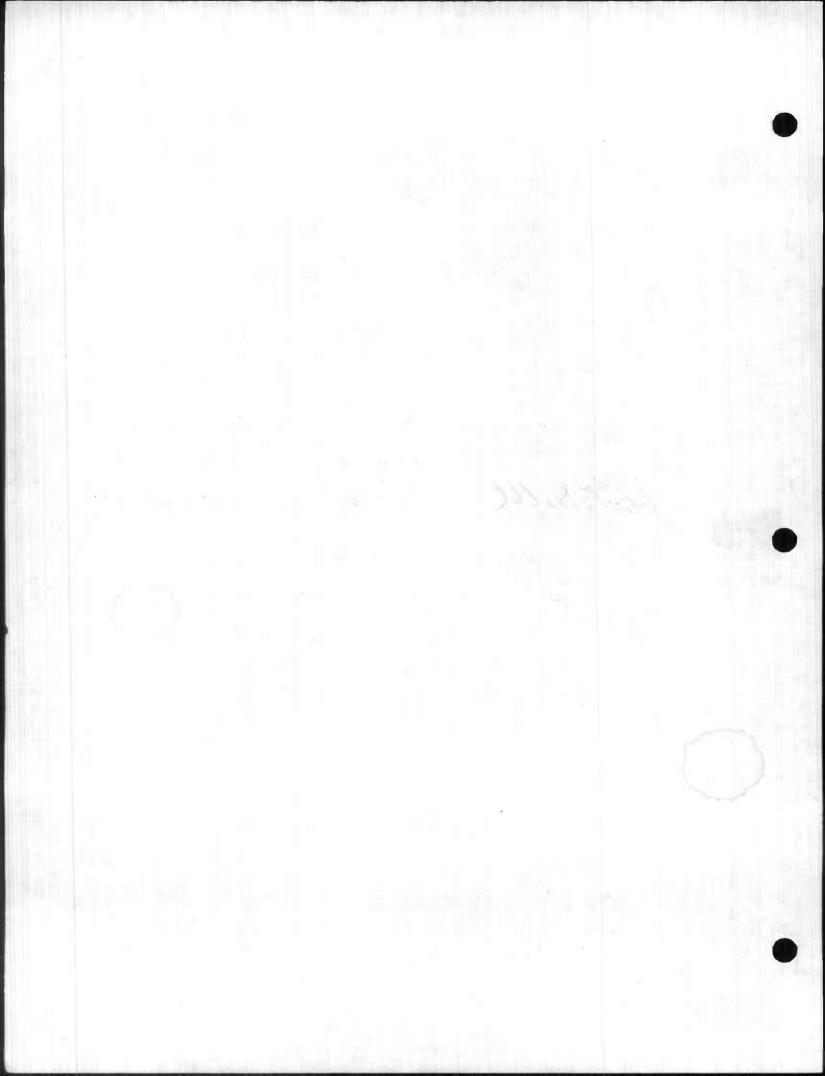
State Registrar

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To the Hospital of within 24 hours at To the Funeral D

3

31. Dete filed (Month, Dey, Year) MAR 29 2000 32. Begistrer's Signeture Seperma



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month March 25, Dey 2000 **Physician** Nathalie Baptiste 5:20 AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Layhill Nursing Center Silver Spring Montgomery 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 64 Yrs. 593-36-9113 Director Oct 30, 1935 Haiti Usuei Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Moulu us me.
Al Mentle Hygiene.
marked other than "natural", or items 23s or 28s-f show
marked other than "satural" or items 25s or 28s-f show MD Montgomery Silver Spring 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3902 Tynewick Drive 20906 Haiti Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black py 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 Housekeeper Hospitality Baltlmore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked other any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) Duverlis Baptiste Idaliene Jeudi 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Evans Faustin - Nephew 3902 Tynewick Drive, Silver Spring MD 20906 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 4/1/00 Brentwood, MD 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Rapp. Funeral & Cremations Services 935 First Avenue Silver Spring, Md 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Metastatic Cholagiocarcinoma 3 months Examiner Due to (or as a consequence of) Examiner or Attending Physicient. The lew requires that the death certificate be executed Ician and burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. physician Physician/Medical tha Due to (or es e consequence of): for use as P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be datached 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 has certificata 1 Yes 2 No 1 ☐ Yes 2 ☒ No Division of Vital director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA shis funaral 28a. Dete of fnjury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? After 5 Pending Investigation 1 Neturel aftar daeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel D Hospital 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical completely (Check only one) To the I within 2 To the 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Anurita Mendhiratta MD,

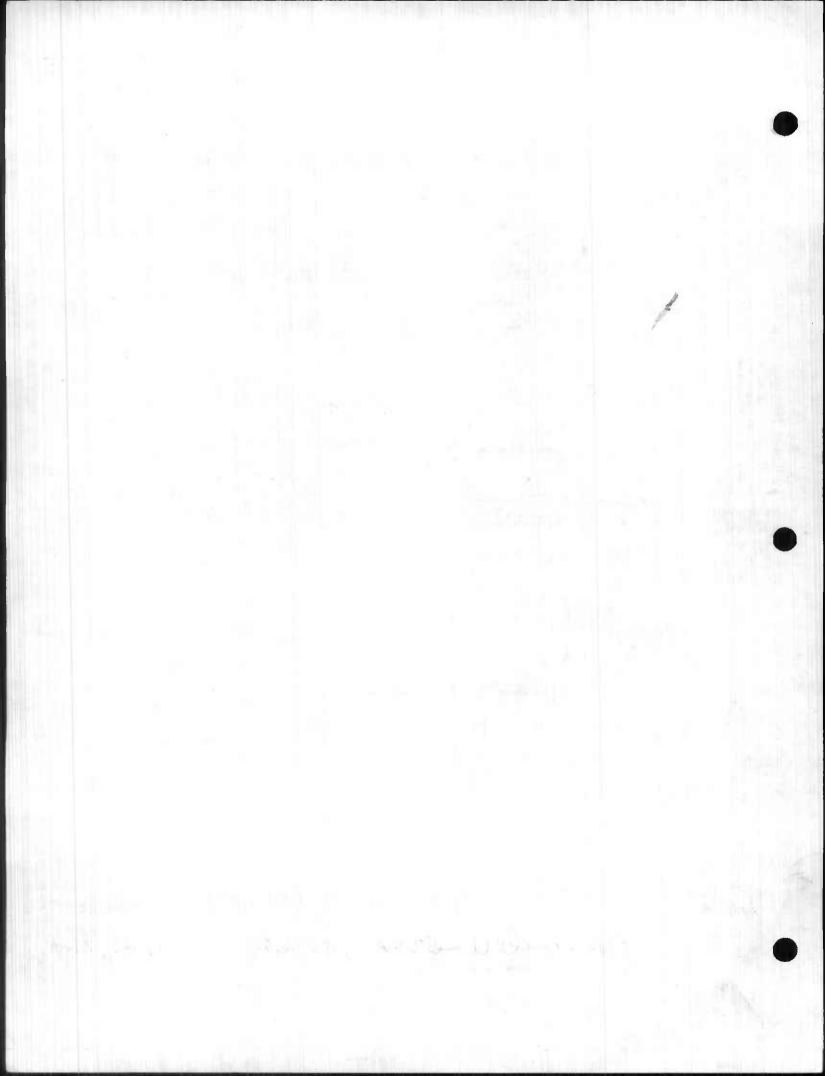
2000

31. Dete filed (Month, Dey, Year) MAR 28

32. Régistrer's Signeture

CHEVE

2401 Research Blvd, Suite#340 Rockville, MD 20854



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Date of Death Day Month **Physician** Virginia Elaine Beck-Smith 1:30 pm 2000 March 23, /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Home Baltimore Essex 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X F 213-28-6705 Yrs. 68 Director August 15. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show 1 Yes 2 No Baltimore MD Abingdon 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 8 눔 Examiner must be 3218 Willson Lane 21009 "natural", or items 23a P.O. 391 United States Funeral death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify: Specify: White À 3 Widowed 4 Divorced the Medical 2 Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Collega (1-4or 5+) Teller / Asst. Manager Banking 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Pages 1 and 2 should be and Mental Dale Amos Hazel Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) . rtment of Health I rtant: If Itam 27 is 37 Honeysuckle Lane Baltimore, MD 21220 Marie Ramey - daughter 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, Stata Chesapeake Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 3-27-2000 Beltsville, MD 22. Name and Address of Facility
CAFA Stephen D. Lohmann, P.A. 21. Signature of Funeral Service 8717 Green Pastures Dr., Towson, MD 21286 Part Lefter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Pancreatic Cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated avents rasulting in daath) Last physician and the burial-tran Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence ot) for use as signed by the aid be detached to 23b. Did tobacco usa contribute to the cause of depth? Part ff. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☑ Onknown þ 24b. Wara autopsy tindings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate To the Hospital or Atlending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 10 1 Yes 2 No 3D DOA 5 ☐ Rasidence 6 ☐ Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide Place of Injury - At home, tarm, streat, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certific 29c. Licanse number D 43725 3/23/00 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95** 

State

Tariq

31. Date tiled (Month, Day, Year)

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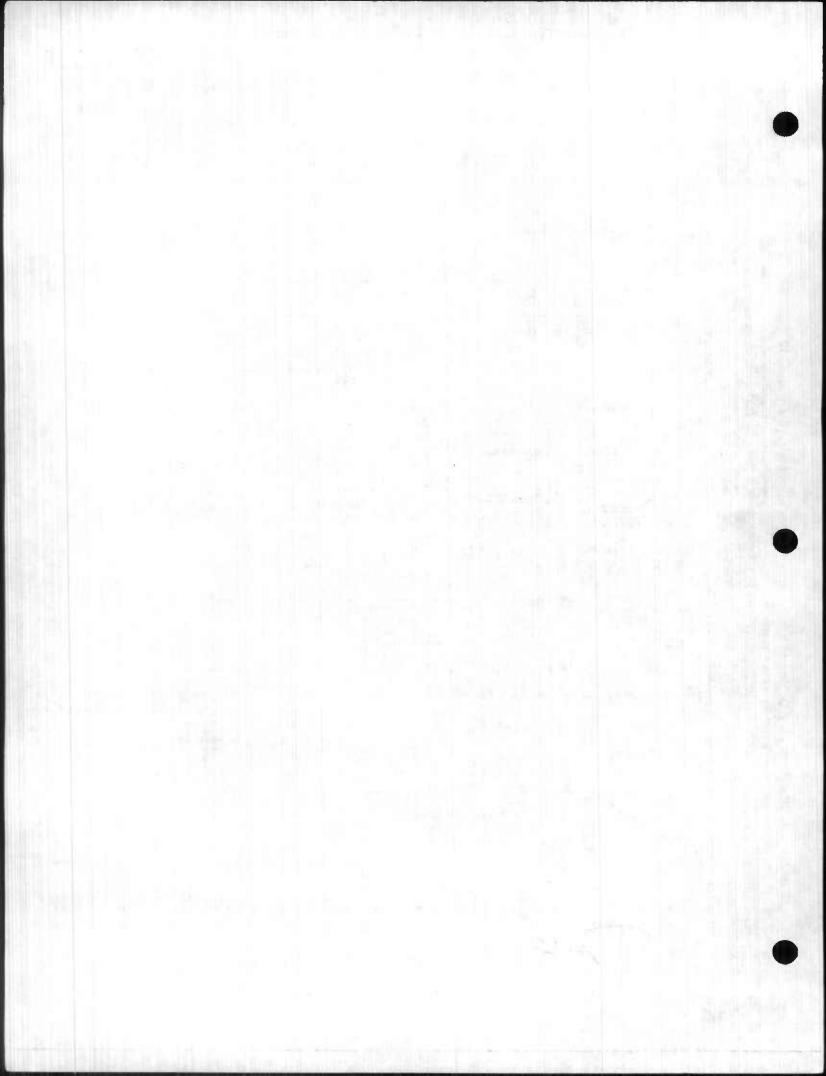
Baltimore MD 21221

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Back River Neck Rd

32. Registrar's Signature

Jeneras



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 5:30 pm Maebelle R. Berry 25, 2000 March 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Mariner Health Care- Silver Spring Montgomery 8. Date of Birth (Month, Day, Yea June 25, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 XF Yrs. 1917 Michigan 82 370-10-2196 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 2917 Bluff Point Lane 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black White etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William John Rowan Ann Elizabeth Pulling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Bluff Point Lane, Silver Spring, MD Austin Luther Berry/ Husband 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3/30 1 Burial 2 □ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2000 Arlington, VA 21. Signature of Funerat Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 amas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final Acute Myocardial Infarction disease or condition resulting in death) 10 min Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide

or Attanding Physician: The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760,

Registrar

10

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or frems 23s eny Injury of other traumatic event, the Medical Exercise.

**Physician** /Medical

Examiner

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Medical Certification: To

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altimore, Maryland

31. Date filed (Month, Day, Year) State MAR 28

29a. Certifier

29b. Signature and title of certifie

Barry Rosenbaum, MD

32. Aggistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

3720 Farragut Ave., Kensington, MD oaks

11X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

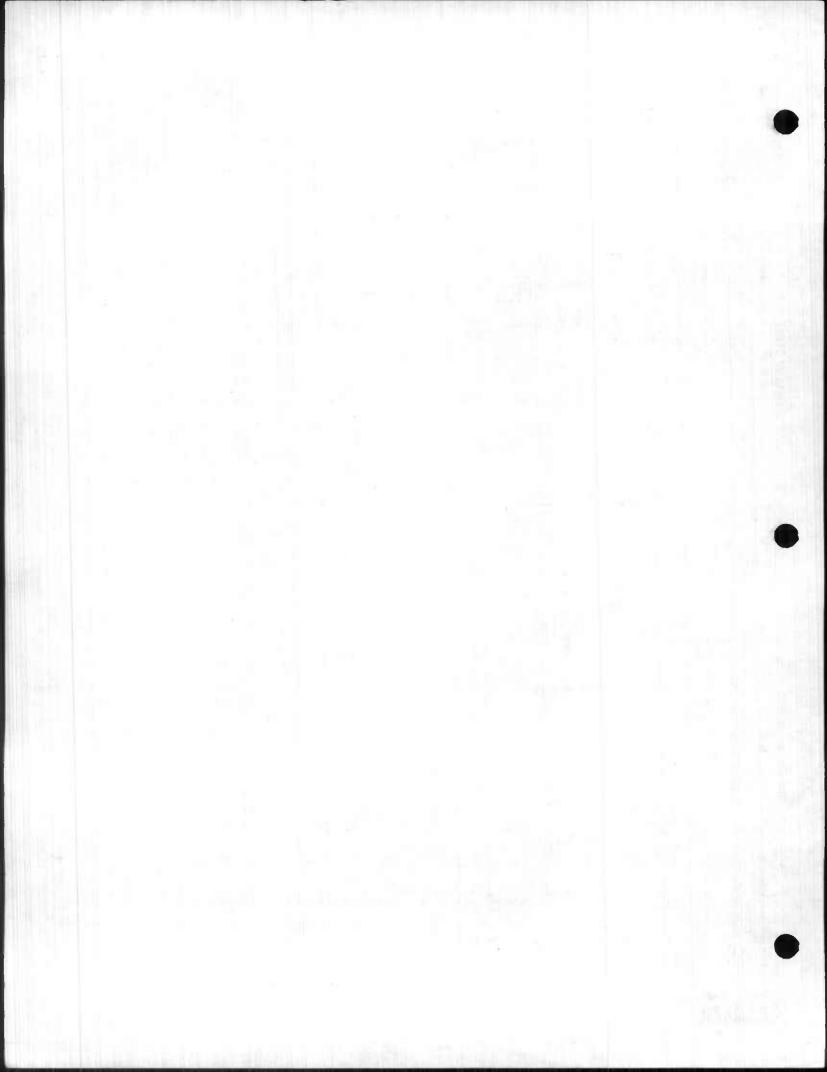
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29c. License number

29d. Date signed (Month, Day, Year)

March 27, 2000

20895



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 25, 2000 Martha March 6:15P. I. Blaschak 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Doctor's Community Hospital Prince Georges Lanham If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Nov. 11, 1920 6 Sax 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) Months Days Hours 1 M XXF 79 Yrs 172-18-9148 Pennsylvania Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Prince George's **Beltsville** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4520 Broad Blvd. 20705 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status Was Decedent Evar in U.S. Armed Forces? Yes 2000 1 Nevar Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Medical Assistant **Hospital** 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Andrew Maurer Anna **Klochak** 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) William Blaschak (husband) same as #10 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Grandview Cemetery 3/29/2000 Johnstown, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 21. Sign#ture of Funerel Service Licensee Donald of Bordwardt Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximate Intervel Between Onset and Death Immediata Causa (Final Acute Urinary Tract Infection 3-1-2000 disaesa or condition resulting in death) Due to (or es a consequence of): Acute Azotaemia 3-20-2000 Due to (or es a consequence of): 8-3-1995 Chronic Obstructive Pulmonary Disease Dua to (or es a consequence of) Right Lower Lobe Pneumonia 3-25-2000 23b. Did tobacco uas contributs to the cause of death? 1 Yes XX No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to complation of causa of death? 24a. Wes an autopsy parformed? 1 Yes 2 No 1 Yes 2/2/No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Director

Funeral

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**Funeral** 

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Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

burial-transit pue physiclan the 95 for usa signed by the a page 2 has certificate this funeral After s after death.

Examiner Physician/Medical Completed by Be Certification: To filled in by

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? Hospitel: XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200No 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stele) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifie XX certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and mannar statad. (Check only one)

completely

within 24 hours a Hospital

To the

29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

0013668

March 27, 2000

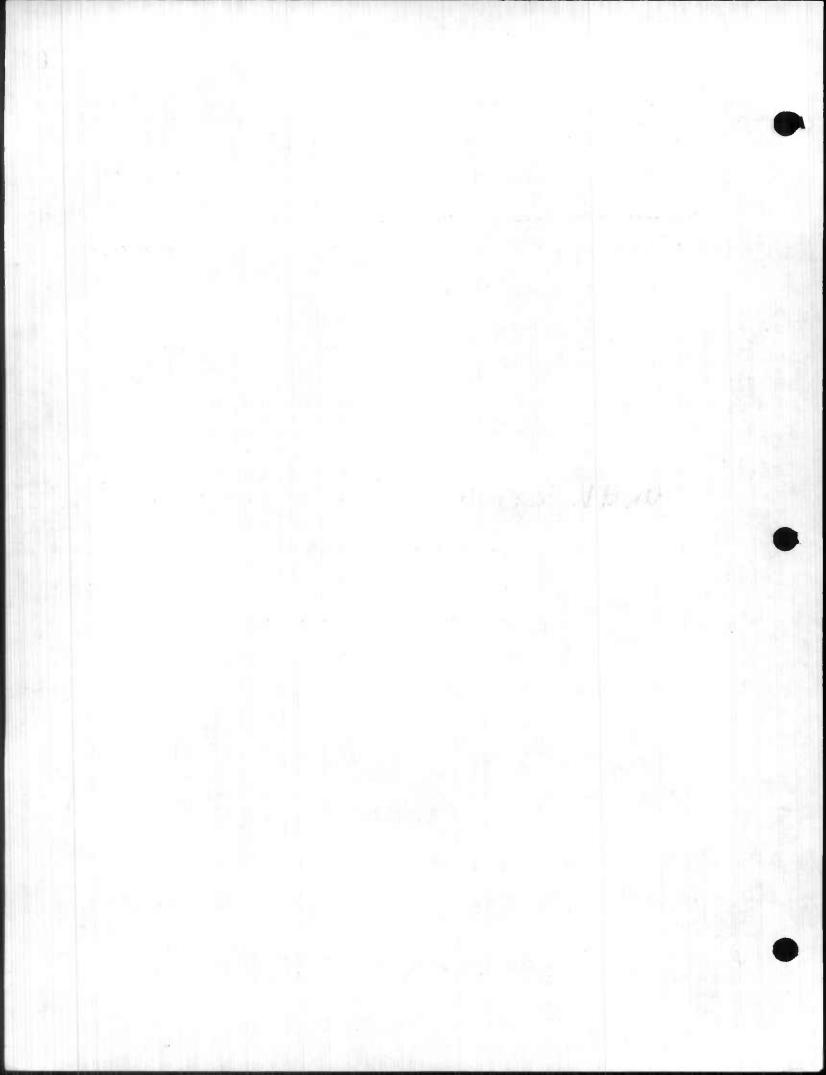
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740

State Registrar 31. Date filed (Month, Day, Year) MAR 29

32. Registrer's Signeture

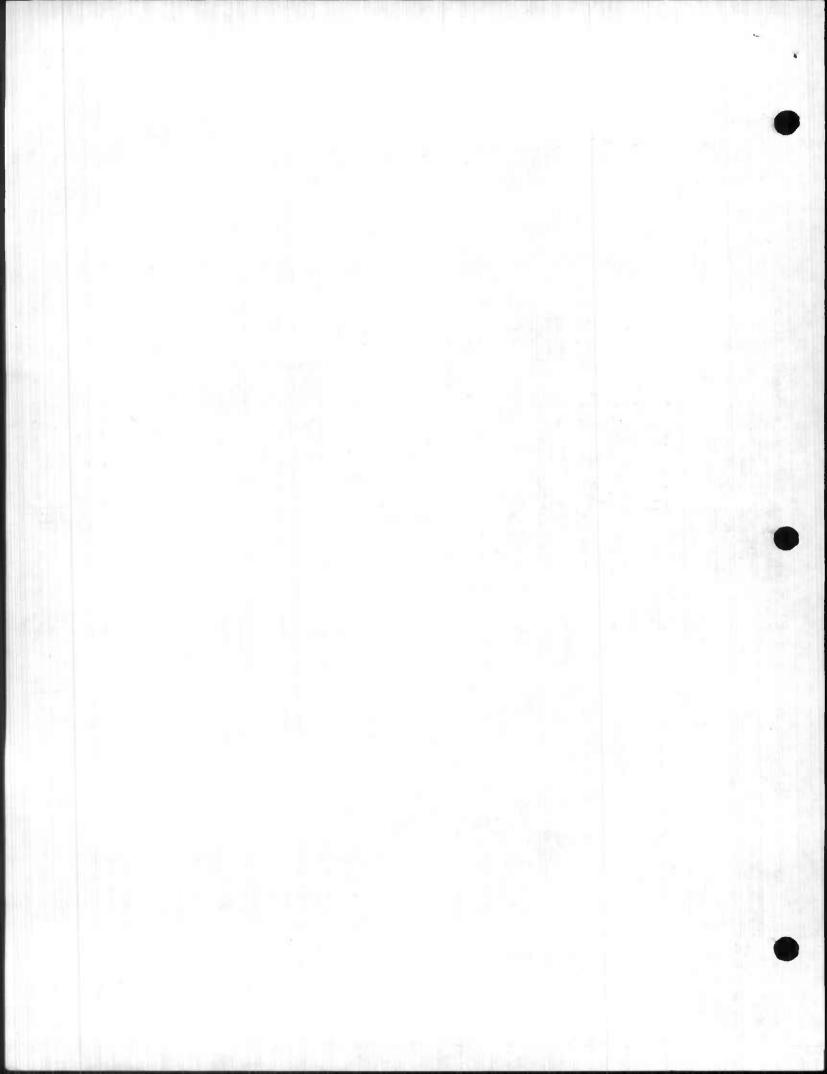
oaks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #12,3/31/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARCH 27, 2000 BRUCE STEPHEN BLOOM 8:27 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY If Under 1 Yee If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Deys 10M 20 F 59 Yrs Director 505.46.1219 Usuel Residence of Decedent NEBRASKA the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified as 1 ☐ Yes 2 ☑ No Director MONTGOMERY POTOMAC MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23s 20854 Funeral 10020 WEATHERWOOD COURT USA death 12. Was Decedent Ever in U.S. Amed Forces? 12 Yes 2 1071-1973 Yes, Give 171-1973 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other treumstic averages. Elemantery/Secondary (0-12) Collega (1-4or 5+) 5+ PHYSICIAN MEDICAL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be HAROLD BLOOM DINA HIMELBLOOM 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10020 WEATHERWOOD CT, POTOMAC, MARYLAND 20854 ARLENE BLOOM/WIFE 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetary, crametory or other plece) 20c. Location - City or Town, State MARCH 1 ◯XBurial 2 □ Cremation 3 □ Removel from State JUDEAN MEMORIAL GARDENS 4 ☐ Donation 5 ☐ Other (Specify) 29, 2000 OLNEY, MARYLAND 21. Signature of Funerel Sarvice 22. Name and Address of Facility EDWARD SAGEL FUNEAL DIRECTION, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast,

Approx. 20852 Approximate Intervel Batween Onset and Death Physician Immediate Cause (Finel disease or condition resulting In daath) /Medical THEIC SCI Examine Examiner burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) pue Box 68760. Physician/Medical Due to (or as a consequanca of) tha for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed I Records, þ 24b. Were autopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mapnar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation After death. 1 Yes 2 No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicida Hospital Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) (0 1437122 8600 OLDGERORE ane end eddress of parson who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Dey, Year) 32. Régistrar's Signature State 2000 Jener MAR 30 Registrar



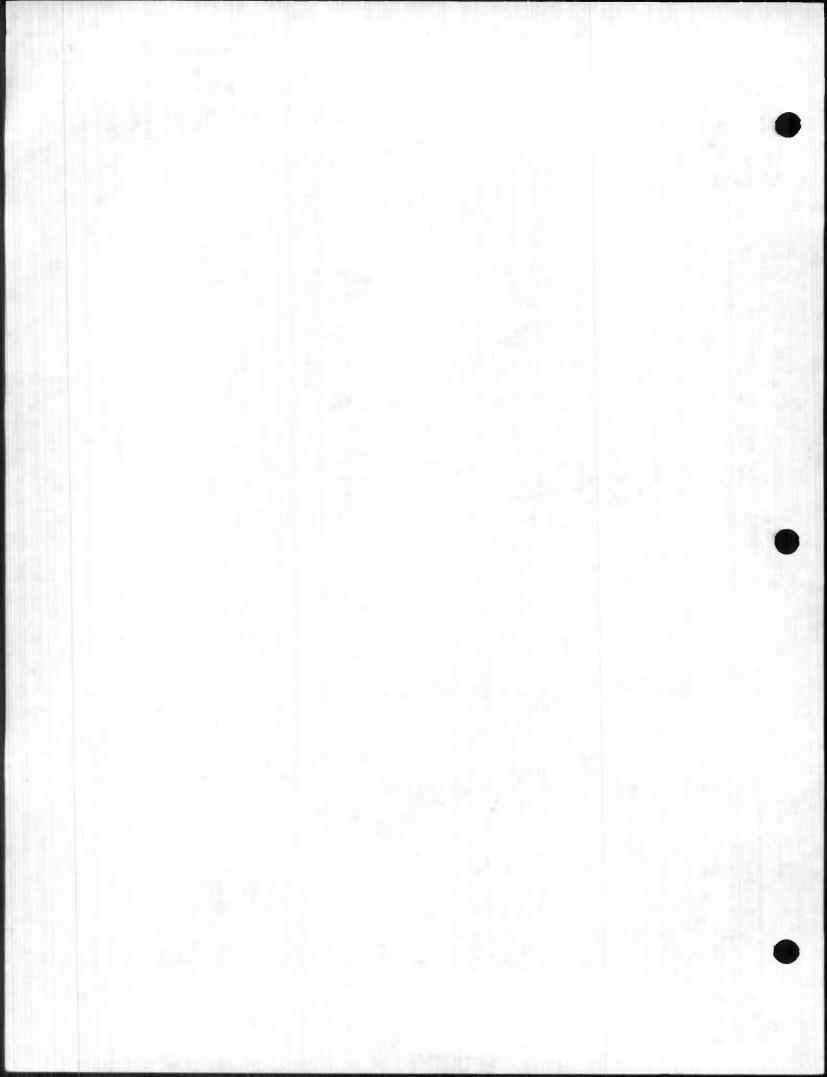
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partment of Health and Mer	ital Hygiene () ()     7	21
ertificate of Death	Ban No.	

			Ce	rtificate	of	Death		Reg. No.			
Physician	1. Decedent's Name (First, Middle, Last, Philip Christopher						2. Date of Dec	22, 200	Year	3. Time of Death	
/Medical	4e Facility Neme (If not institution, give				-	4b. City, Town, or	March Location of Deeth	_		6:50 A.M.	
Examiner	2301 Stratton Driv					Rockvil	lle		tgame	ery	
Funeral Director	214-00-0774	x 7. Age (In y. Q M 2□ F 4.	rs. lest birthdey) 7 Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min	. (Month, De	h y, Year) 20, 1952	9. Birtho Coun Washi	laca (State or Foreign try) ngton, D.C.	
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23a or 28a-f show that De notified at	Maryland Montgome		Rockv							1 ☐ Yes 2 No	
or 284-f	10e. Street and Number	- L y	ROCKV.	10f. Zip (	Code			10g. Citizen of	What Coun	try?	
23a o mithe	2301 Stratton Driv	e			20	0854	1	United :	State	S	
or hems	11. Merital Stefus  1 Never Merried 2 Married  3 Widowed 4 ADvorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decede If Yes, speci			Specify Yes or No- to Rican, etc.)		ca - America ck, White, o y: Whi	etc.	
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2 should be filed within to end Mental Hygiene. Is marked other than raumatic event, present	17. Father's Name (First, Middle, Last)						me (First, Middle,	Maiden Sumer	ne)		
To	Philip Francis Bow  19e. Informant's Name/Relationship (Ty		10h Maili	na Address	/Street	Hester 1	Uonovan Jural Route Numbe	or City or Town	State 7in	Cadal	
traum traum	Hester D. Bowers/M										
C office	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)  20c. Location - City of Cemetery, cremetory or other place)									wn, State	
Important if flam 27 is marked other than any injury or other traumatic event, the strong.  To Be Comp.	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens					ss of Facility Ro				aryland neral Home Avenue,	
Attending Physician: The law requires that the death certificate be executed and and death.  Attending Physician: The law requires that the death certificate be executed with the death of the attending physician and by the funant director, page 2 should be detached for use as the burial-transit using the page 2 should be detached for use as the burial-transit using the funant of the funant diffication: To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or limited the cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in deeth) Last	NARCOTIC INTO		quence of):						Interval Between Onset and Death	
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certificate he rector, page							100	res 2□ No	10	Yes 2□ No	
	25. Was case reterred to medical examiner?	fospital:			Oth	Ar:	eth (Check only o		40. 14		
deeth. ctor: After this c y the funaral dire	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury  Month, Day Year,  3/22/00	28b. Time of Injury 6:		kc. Injur Wor	4 LI Nursing	Home SX Residence Page 128d. Describe Page 1			ject ingested	
within 24 hours after deeth. To the Funeral Director: After it complately filled in by the funeral Medical Certification:	3 Suicide 4 Homlcide  4 Homlcide  4 Homlcide  4 Homlcide  4 Homlcide  5 Would not be determined building, etc. (Specify)  found at home							26f. Location (Street and Number or Rural Route Number, City or Town, State) 2,301 Stratton Drive Rockville, Md.			
24 hourstely fill		nician: To the best of my kener: On the basis of examinand manner stated.									
To the comple	29b. Signature and title of certifier	N. 14		29c.		e number		29d. Date signe March 2			
State	30. Name and address of person who co	mpleted cause of death (III	1.1		n S	treet, B	altimore	, Maryl	and 2	1201	

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 00 11721

			Ce	ertificate of	Death		Reg. No.	, 1	1161				
	1. Decedent's Name (First, Middle, L	nst)				2. Date of De Month	ath	Vanc	3. Time of Death				
Physician /Medical	JEAN	SIME	BRAND			MARCH	25, 200	O Year	5:11 A.M				
Examiner	4a Facility Name (If not institution, gr	ve street and number)			4b. City, Town, or	Location of Deat	h 4c. County	of Death					
	COLLINGSWOOD NUR	SING CENTER			ROCKVII	LE	MON	TGOME	RY				
Funeral Director	577-01-1077	Sex 7. Age (In your 10 M 2 F 91	rs. last birthday Yrs.	Months Days		(Month, Da	th by. Year) 5, 1908	Count	aca <i>(State or Foreign</i> ry) sylvania				
2 .	Usual Residence of Decedent  10a. State 10b. County	100	City, Town or L	acetion				140	d. Inside City Limits				
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or 2	10e. Street and Number			10f. Zip Code			10g. Citizen of \	Mhat Count	ry?				
23a	20013 Wanegarden	7			0874		United						
within 72 hours after death with the Manyland ens. then "natural", or items 23s or 28s-f show its Medical Establish mast be notified at empleted by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas:	U,S. 13.	Was Decedent of If Yes, specify Cu 1☐ Yes 2☑ No	of Hispanic Origin? (Specify Yes or N uban, Mexican, Puerto Rican, etc.) No Specify:		Specify	ca - America ck, White, e					
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marked marked marked av	Robert Jarra	n Sime			Anna		McCormi	.ck					
Care and	19a. Informant's Name/Relationship				et and Number or R				Code)				
Health Health Wher tr		aughter			den Court				0874				
Pages 1 and nent of Health ant: If Itam 27 ary or other to	1 Burial 2 Cremation 3	Marjea Greene, Daughter   20013 Wanegarden Court, Germantown, MD 200. Method of Disposition   200. Place of Disposition (Name of cemetery, crematory or other place)   Date   Mar 29,   200. Location - City or   Mar 29,   2000   Washington											
partin Prings	21. Signature of Funeral Service Lice			22. Name and Add			FUNERAL		DO				
SOFER	Much	Hi	1	O E. DEE	R PARK DE				20877				
	23a. Part / Enter the dispase, or cor shock, or heart failure. List only	nplications that caused the de						1	Approximate				
Physician	single, or reservant tallers. List only	one cause on each line.							Interval Between Onset and Death				
/Medical	Immediate Cause (Final	DNEIMONT A					VEADC						
Examiner	disease or condition resulting in death)  PNEUMONIA  PNEUMONIA  Due to (or as a consequence of):												
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ng physician and a as the bural-transit	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):												
death e atte	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?				
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The law ate has page 2						10	Yes 2 No	10	Yes 2 No				
cartificate rector, pa	25. Was case referred to medicat				26. Place of De	eath (Check only							
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ang Pnysolan: h. After this cartific funaral director, tion: To Be	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inj			how injury occur		,				
tal or Attanding P rs after death. al Diractor: After i ied in by the funer. Certification:	3 Suicide 6 Could not l	28e. Place of Injury - At building, etc. (Spe		treet, factory, office			Street and Numb wn, State)	per or Rural	Route Number,				
To the Hospital or Attending Physician: Tha I within 24 hours after death.  To the Funeral Director: After this cardificate h completely filled in by the funeral director, page.  Medical Certification: To Be Com	29a. Certifier 1 Certifying P	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the nvestigation, in my	time, date and plac opinion, death occ	e, and due to the surred at the time,	cause(s) and modate and place,	anner as sta and due to	ated. the cause(s)				
Within To the comp	29b. Signature and title of contribution	· I bell		29c. Licer	nse number		29d. Date signe	d (Month, E	Day, Year)				
	DA 10	Idman	mi	D37	108+		MARCH	28,	2000				
5	30. Name and address of person who	completed cause of death (fit	em 23a) (Type		J 1		IMICI	20,	2000				
	AIMEE SEIDMAN, M				NORTH POT	FOMAC - MI	D 20878	3					
State	31. Data filed (Month, Day, Year)	32. Registrar's Sig	nature	-		,							
Registrar	MAR 29 2	000 Seneva	1 1.	Spark	2								

DHMH 16 Ray 6/95

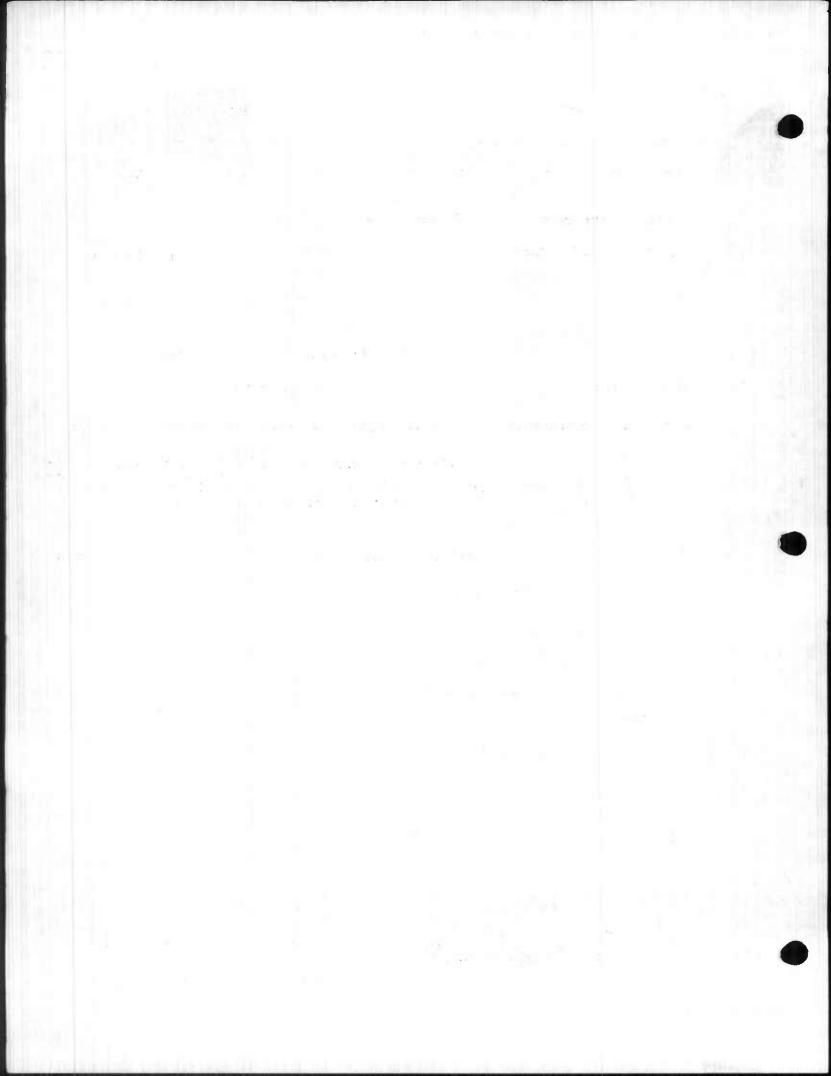


State of Maryland / Department of Health and Mental Hygiene

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					Certific	ate of	Death		Reg. No.	O	11166	
Physic	ian	1. Decedent's Name (First, Middle, L	ast)	1				2. Dete of De Month	eath Day	Year	3. Time of Deeth	
/Medi		Richard N. Br	i11					March	28, 20		1:15 AM	
Exami		4e. Facility Neme (If not institution, g					4b. City, Town, or	Location of Deal	th 4c. Count	of Death		
		Montgomery Hosp					Rockvi			gomer	У	
Funeral Director		5. Social Security Number 6. 119-03-3488 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. lest 78	Yrs. If Ur Mont	ths Days			rth ey, <i>Year</i> ) 3, 1921	9. Birthp Coun New	place (Stete or Foreign htty) York	
yland		10a. State 10b. County		10c. City, To	own or Location					1	10d. Inside City Limits	
Mar	to	Maryland Montgon	nery	Gait	hersburg	g					1 No Yes 2 No	
th with the 23a or 28	Funeral Director	10e. Street and Number 1517 Tanyard Hil.	l Road		10f.	Zip Code	20879		10g. Citizen of Unite			
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiena. If Item 27 is marked other than "naturel", or items 23a or 28e-f show or other traumetic event, the Mad call Evan	by	11. Marital Stalus  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:				HispanIc Origin? (S pan, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: White		
72 h natu	etec	15. Decedent's l (Specify only highest g	Education rade completed)	16	6a. Decedent's U	Jsual Occu	pation during most of wo	rkina	16b. Kind of B	usiness/Inc	dustry	
na.	Completed	Etementary/Secondary (0-12)	College (1-4or !	5+)	life. DO NO	Tuse retire	ed)	rang				
led v lygie nt. In		47 F-11   1   1   1   1   1   1   1   1   1	5+		At	torne	2			Emp1	oyed	
be fi	Be	17. Father's Name (First, Middle, Las	1)					me (First, Middle	, Me <i>id</i> en Su <i>m</i> er	10)		
J Mer Jarke	10	Abraham Brill						chwartz				
le m le m		19a. tnformant's Name/Relationship					t end Number or R					
permit. Peges 1 and 2 should be filed within Deportment of Health and Mental Hygiena. Important: If item 27 is marked other than any injury or other traumatic event, the Meonce.		Sharon H. Pope/Co  20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3  4 □ Donation 5 □ Other (Spec	Removei from State	20b. Place ceme	Neme of or other ple		d, Gaith  Date  March 30,  2000	20c. Location	- City or To	own, State		
permit. Peges 1 ar Depertment of Hea Important: If item: any Injury or other		y Fur	la, Maryland Funeral Home ry Avenue,									
		23e. Part1. Emer the disease, or collaboration shock, or heart failure. List only	nplicetions that caused	the deeth. D			Marylan				Approximate	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	e. Liver							1	Interval Between Onset end Deeth	
	ě			Due to (or as	e consequence	of):						
thet the death certificate be executed ed by the attending physician and detached for use as the burial-trensit	al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, Disease or trijury	b. Gastri		a consequence	of):				2	2-3 Years	
ath certificate be axe attending physician a for usa es the burial-	/Medical	thet initiated events resulting in death) Last	Due to (or as a consequence of):									
atter	clar					107						
of the de	Physician/	Part li. Other significant conditions	contributing to death b	ut not resulting	In the underlyin	ng cause gi	ven In Part I.		23b. Did tobacco use contribute to the cause of death?			
res thet tigned by	by	Esophageal Va	rices					1 🗆	Yee 2□No	3 Prob	bably 4\overline{\text{\text{\text{\text{Unknow}}}}	
he law requires the has been signed age 2 should be considered and the constant of the constan	Completed							24a. Wes	an autopsy ormed?	ava	ere eutopsy findings ailable prior to mpletion of cause death?	
F								1 🗆	Yes 2 No	10	Yes 2□ No	
vician: The certificate rector, pay	Be	25. Was case referred to medical examiner?	Hospital:			011		ath (Check only				
Ing Phys Wher this uneral di	ation: To	1 Yes 2 No  27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28a. Date of Inju (Month, De		Oulpatient 3  Time of Injury  M	28c. Inju Wo			dence 6 AOth how Injury occur		y)Hospice	
Ital or Attending its offer death.  Tal Director: After led in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined						rumber or Rural Route Number,				
To the Hospital or A within 24 hours effar To the Funeral Director Completely filled in b.	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hyelclan: To the best of miner: On the basis of and manner sta	examinetion a	ge, death occurr and/or investiget	ed at the ti	me, dete and ptace opinion, death occu	e, and due to the urred et the time,	ceuse(s) and me date and ptace,	end due to	eted. the cause(s)	
To the To the Comp	X	29b. Signeture and title of certifier	0			29c. Licens	se number		29d. Dete signe	d (Month, I	Dey, Year)	
8+1		30. Name and address of person who	completed cause of d	eeth (Item 23s	a) (Type, Print)	Ι	35996		March 28, 2000			
		Linda M. Burrell	M.D. 210	01 Medi		k Dr.	#210, S	ilver Sp	oring, M	D 209	02	
Sta Registr		31. Date filed (Month, Dey, Year) MAR 3 1		er's Signature	B. A.	pork	2					

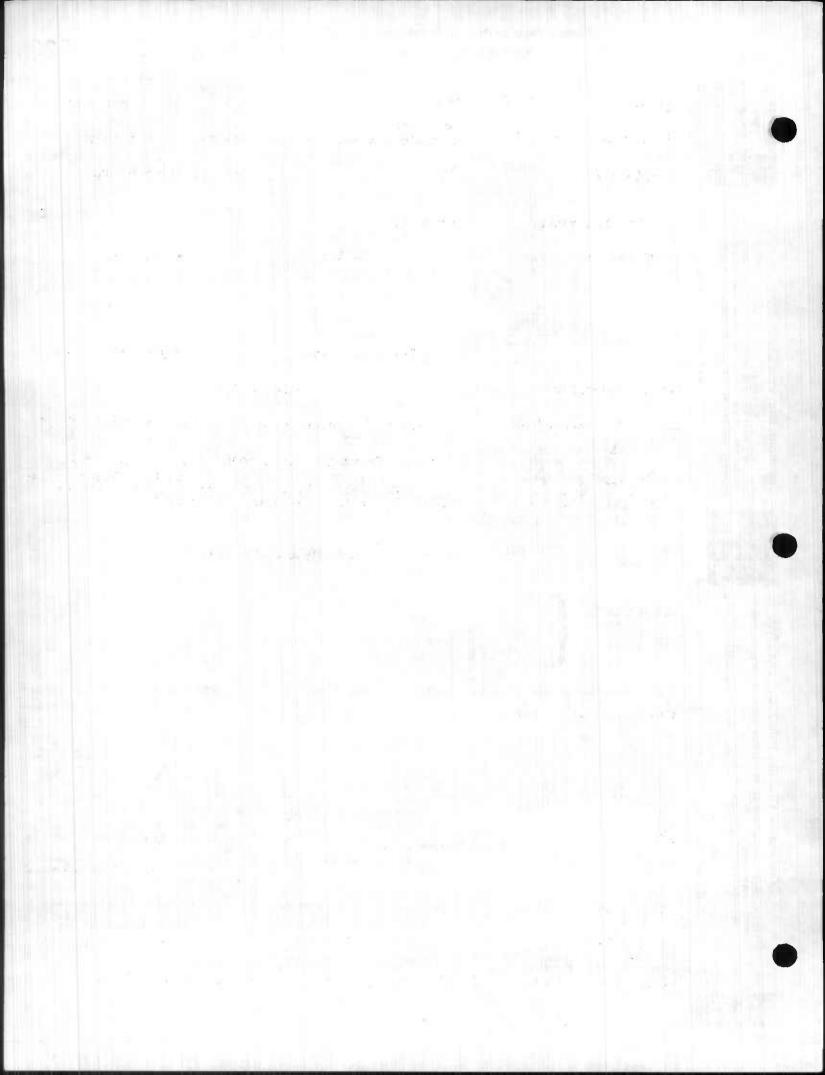
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month V. BUITENDORP 0200 **Physician** TEANNETTE 2000 22 MARCH /Medical 4a Facility Name (If not institution, give street and number) MEDIPLEX OF 4b. City, Town, or Location of Death 4c. County of Death Examiner 19301 WATKINS MILL PORD MONTGOMERY VILLAGE MONTGOMENY VILLAGE MONTGOMERLY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 20XF Yrs. 94 Oct. 10, 1905 Michigan **Director** 070-34-3837 Usual Residence of Decedent with the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in ment of Health and Mental Hygiena.
ant: if item 27 is marked other than "natural", or itema 23a or: ury or other traumatic event, the Medical Examines must be It. 20855 18909 Muncaster Road United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Department Store Sales Associate 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Henry Vanderplow Alberta Dykema 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 18909 Muncaster Road, Rockville, Maryland 20855 Warren Buitendorp/Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2000 24, permit. Page Department of Important: If any Injury or once. 4 □ Donetion 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ARTERIOSCURATIC CANDIONASCULIA DISCOS Examiner Due to (or es a consequence of): Examiner attending physicien and for use as the buriel-transit daeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medicai Due to (or as a consequence of): use as t 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown LPT. HIP TOURTURE Division of Vital Records. by 50 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 s hes 2000 1 ☐ Yes 1 ☐ Yes certificate 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28d. Describe how injury occurred funerai 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? Certification: Stood UP FROM CHAIR, SUPPORD & FOLL W After 5 Pending investigation ar death. 1 Yes 2 No MAGGINTATE ODOS 18 YARUNTE 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 18409 MUNICITED MILL 20 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide Hospital or filled in ROCKULUT, MD 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifing within 24 hor To the Fune complately fi edical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signe 0 MARCH 24 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Pockvius I. MARGOUS, M.O. 11125 ROCKYLLE BIKE 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State MAR 2 7 2000 Registrar

**DHMH 16 Rev 6/95** 



**Physician** /Medical Examiner

Department of Important: If any injury or page

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r then "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene.
ant: If item 27 ie marked other then "natural", or the ury or other traumatic event, the Medical Exerting

21215-0020

Saltimore, Maryland

Box 68760.

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Division of Vital Records.

Directo

Funeral

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Completed

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buriel-trans the for use es this certificate has director. funerai After

Examiner Completed by Physician/Medical Be Certification: To filled in

The law requires that the deeth certificate be executed Physician: Attending al or Attandin s after deeth. I Director: Aft id in by the fur To the Hospital of within 24 hours at To the Funerel D compietely

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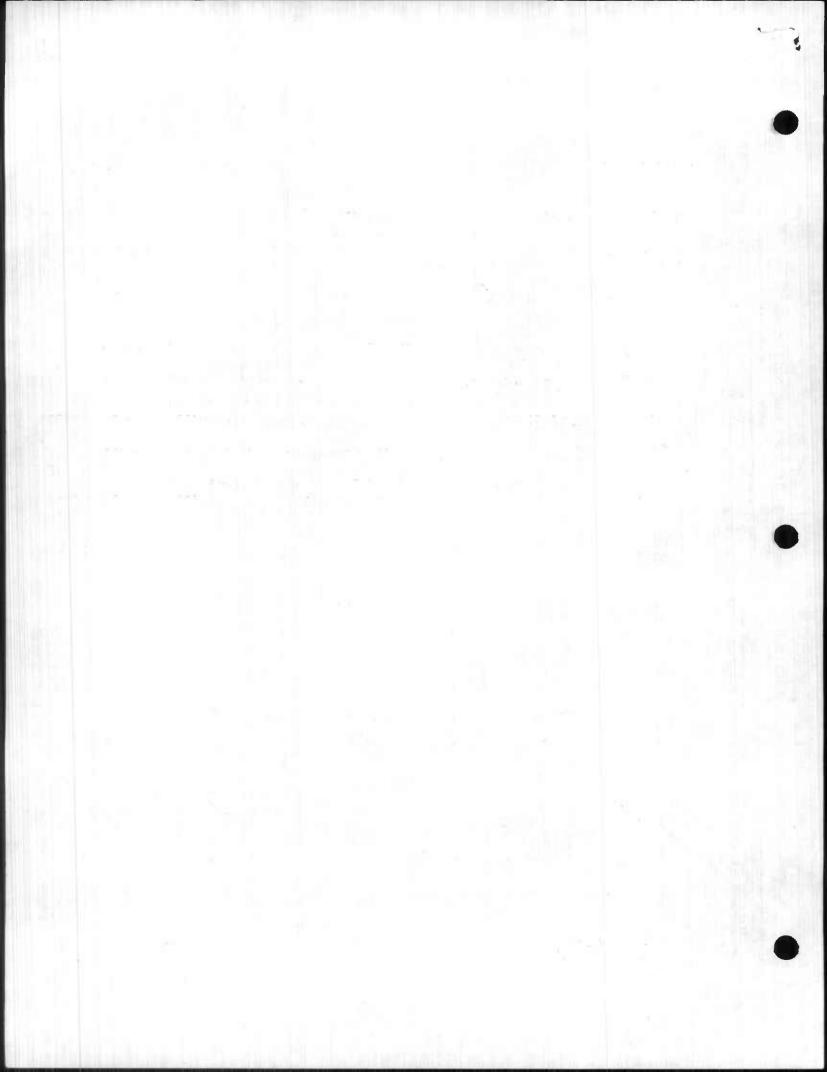
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Dete of tnjury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Netural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26516 March 26, 2000

31. Date filed (Month, Day, Year) MAR 28 2000

Gilson, M.D., 1475 Taney Avenue, Suite 204, Frederick, Maryland 21702 32. Registrar's Signature Serena

of person who completed cause of death (Item 23a) (Type, Print)

souls



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gertrude C. Busse1 March 27 2000 10:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours 1□ M 2₩ F 216-12-4537 76 June 16, 1923 Maryland Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location or 25a-1 show be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Berns 23a 1115 Cornell Lane 20602 USA Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 8 Saltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 1 2 College (1-4or 5+) General Manager Vending Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumatic even Be Charles Ross Cleaves Leafy Virginia Lockhart 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly Brady / Daughter 1115 Cornell Lane, Waldorf, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a, Method of Disposition Dete 20c. Location - City or Town, State 1 Burlal 2 Cremetion 3 DA John's Lutheran Ch. 03/30/00 Winchester, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signatura of Funeral Service 11800 New Hampshire Avenue Silver Spring, Maryland First the disease, or complications that used the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, neer failure. List only one cause or much line. Approximate Intervet Between Onset end Deeth **Physician** /Medical 48 HRS SEPSIS diseese or condition resulting in deeth) Examiner PNEUMONIA 48 Has I I AT I RAL The law requires that the death certificate be executed physician and s the burief-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Rheumatoid Arthritis þ Records. should be 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: funeral director. Be 25. Wes case referred to medical exeminer? 26. Placa of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? After Neturel 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident investigetion 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Hospital TE Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) within 2 To the \$ 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier

State Registrar

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31. Dete filed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Deale Churchton

32. Pegistrer's Signeture

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Road

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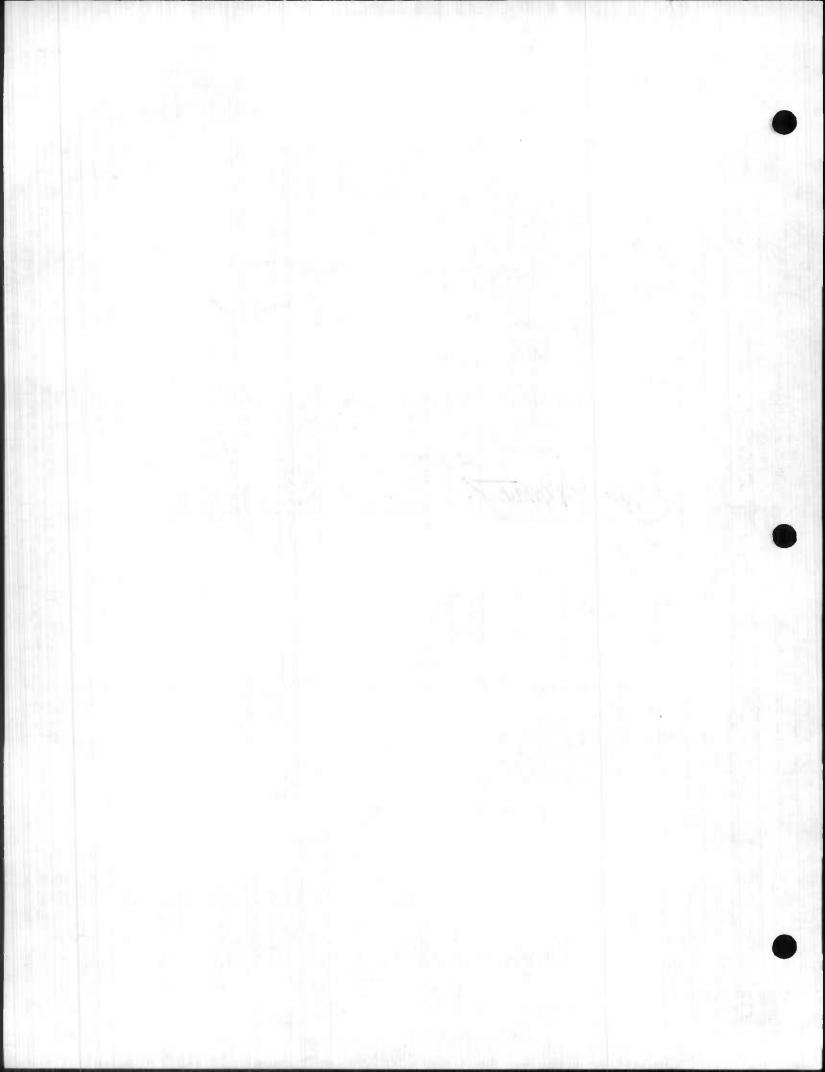
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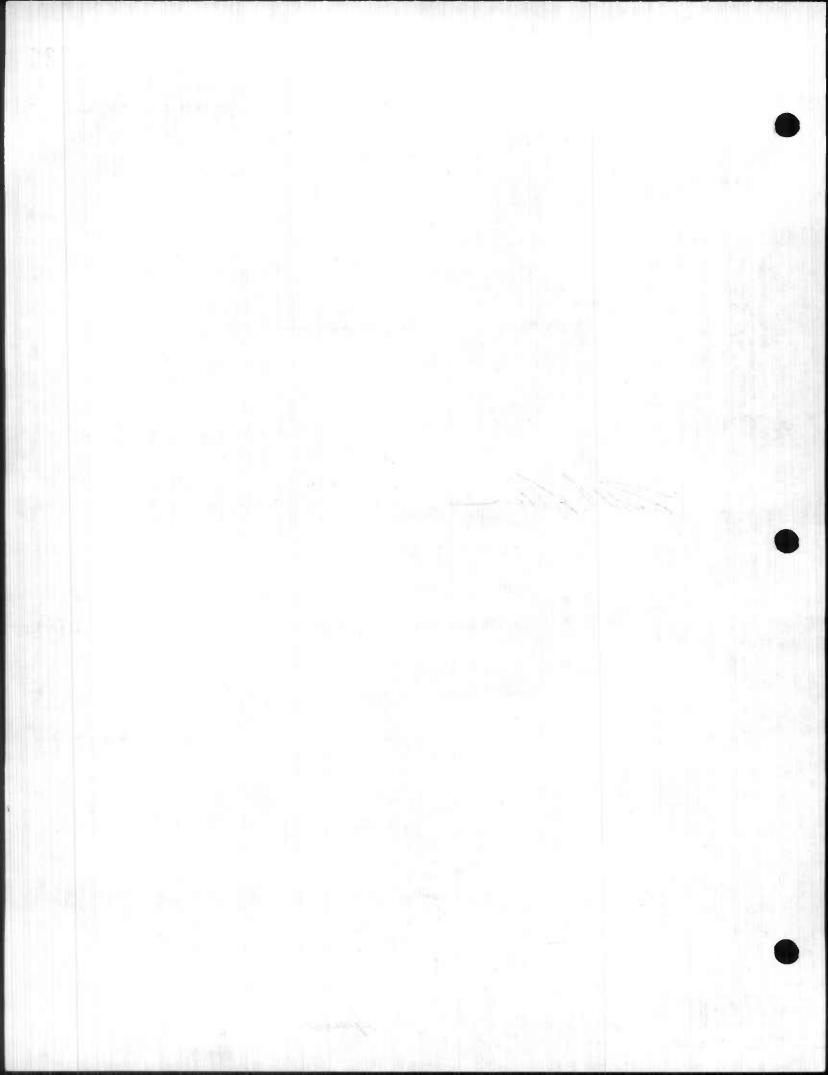
State of Maryland / Department of Health and Mental Hygiene

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			C	ertificate	of D	eath		Reg. No.	•	11/20	
Dhuniaian	1. Decedent's Name (First, Middle, L.	ist)					2. Dete of Month	Deeth Dev	Year	3. Time of Death	
Physician /Medical	KATHARINA	MARIA	В	URBELO	)			,	., 2000	01:47 P	
Examiner	4e Facility Name (If not institution, gi		prod.		4b.	-	n, or Location of D	eath 4c. Cou	inty of Death		
194										imore	
Funeral Director	092-26-9892	Sex 1 □ M 2 1 F	e (In yrs. last birthda 76 Yrs.	y) If Under 1 Months I	Deys	If Under 24 Hours	Min (Month	Birth Dey, Year) 6, 1923	9. Birthp Cour Germ	place (State or Foreign htry) any	
P	Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					11	IOd. Inside City Limits	
with the Maryland a or 28a-f show Libe notified at Director											
off the Ma or 28a-1 s be notified Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen	of What Cour	ntry?	
Sa or at Di	403 Cassell Close			211	5.8			Uni	ted Sta	ates	
her death r Herre 23 siner must	11. Merital Status	12. Was Decedent I	Ever in U,S. 13			panic Origin	n? (Specify Yes or Puerto Rican, etc.		Rece - Americ Bleck, White,	can Indian,	
020 020 by	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 Yes 244  If Yes, Give  Year or Detes:	4o	1 ☐ Yes 2 ☒No Specify:						White	
I 21215-0 ad within 72 ho system. ver than "netur it, the Medical.	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	cedent's Usuel (	Occupati done du	ion iring most o	l working	16b. Kind o	f Business/Inc	dustry	
121 Pan Pan mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)	ve kind of work DO NOT use	retired)						
d Age	17. Fether's Name (First, Middle, Las	3	Home	emaker	1	IR Mother's	Name (First, Mic		r Home		
yland Mental H Mental H mked off rife aver	Heinrich Schmitz						Klopp	die, weiden bui	ioiitoj		
THE PERSON IN	19a. Informant's Neme/Relationship	Type, Print)	19b. Me	itina Address (S			or Rural Route No	mber. City or To	wn, Stete, Zic	Code)	
<b>在压器</b> 6	Gregory Burbelo	(Son)					estminst				
Te, a learn other other	20a. Method of Disposition		20b. Place of Dis		of		Dete		on - City or To	own, Stete	
Page minit	1 ☑ Burial 2 ☐ Cremetion 3 [ 4 ☐ Donation 5 ☐ Other (Speci		Meadow Br				3/25/00	Westm	inster,	MD	
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00 88588	11111	Men		1212 W	est	Old L	iberty R	d What	P.A.	m 21797	
	23a. Part 1. Enter the disease, or con shock, or heart tailure. List only	plications that caused	the death. Do not a	inter the mode of	of dying,	such es ca	rdiac or respireto	ry errest,	eru, r	Approximate	
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/Medical Examiner	Immediate Cause (Final disease or condition				1 HOUR						
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60, be assouted iclan and bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
2 2 2 2 E	cause. Enter Underlying Cause (Disease or Injury that initiated events	Ú.	ARY ARTE		EAS	E			-	1 YEAR	
ox 6876(certificate be nding physicial use as the but	resulting in death) Last		Due to (or es e cons	equence of):							
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4 Pos	Total agranount conductors	orthoday to death of	A not resoning in the	underlying cad	SO GIVOI	THIT OIL I.		Yes 2MN			
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Records, le law requires to least been signe tge 2 should be omplieted by							24a. V	Ves an eutopsy erformed?	24b. W	ere autopsy findings	
The law requirate has been s. page 2 should				_			-   '		CO	empletion of cause deeth?	
i Re law ate has page 2								□Yes 2 N	0 1[	Yes 30 No	
f Vitai Ruyaiclan: The I	25. Was case referred to medical examiner?					26. Place o	f Death (Check or	nly one)			
Of Vita Physician: this certific mai director.	1 ☐ Yes 200 No	Hospital: 1 Inpatie		ent 3 DOA	Other	. 4□ Nurs	ing Home 5□ F	lesidence 8 🗆	Other (Specif	לע)	
ng Pi	27. Manner of Death	26a. Date of Injur (Month, Day	Year) 28b. Time tnjury		. Injury & Work?		-	ibe how injury oc	curred		
Attending releash. Sector: Alte by the fune	Accident investigation    Accident investigation   Suicide   6   Could not be			М		es 2 No					
Division of an or Attending P is after death.  al Director: After ted in by the funeric Certification:	4 Homicide determined		iry - At home, farm, i :. (Specify)	street, factory, o	office			n (Street end Ni Town, Stete)	mber or Hura	al Route Number,	
Principal Co.	00.00 Via.00										
Division or to the Hospital or Attending Phwithin 24 hours after death within completely filled in by the funeral completely filled in by the funeral Medical Certification:		nysician: To the best of niner: Op the basis of and manner sta	examinetion end/or								
Me the	29b. Signature and title of certifier	( ) /	1	29c. L	icense r	number		29d. Dete sj	gned (Month,	Dey, Year)	
F 3 F 8	Dann H	DUA / /	ull M	V. D	323	319		2/	211	00	
	30. Name and address of person who	completed cautes of de	asth (flors 23a) (Turn	a Print)				1			
	RAYMOND HENRY		R, M.D.,		OSL	ER D	RIVE TO	OWSON.	MARYL	AND 21204	
State	31. Date filed (Month, Day, Year)	32. Registra	r's Signeture						The state of the s	mem the time for	
Registrar	MAR 2.9	ann Se,	was to	9 10	ak	11					

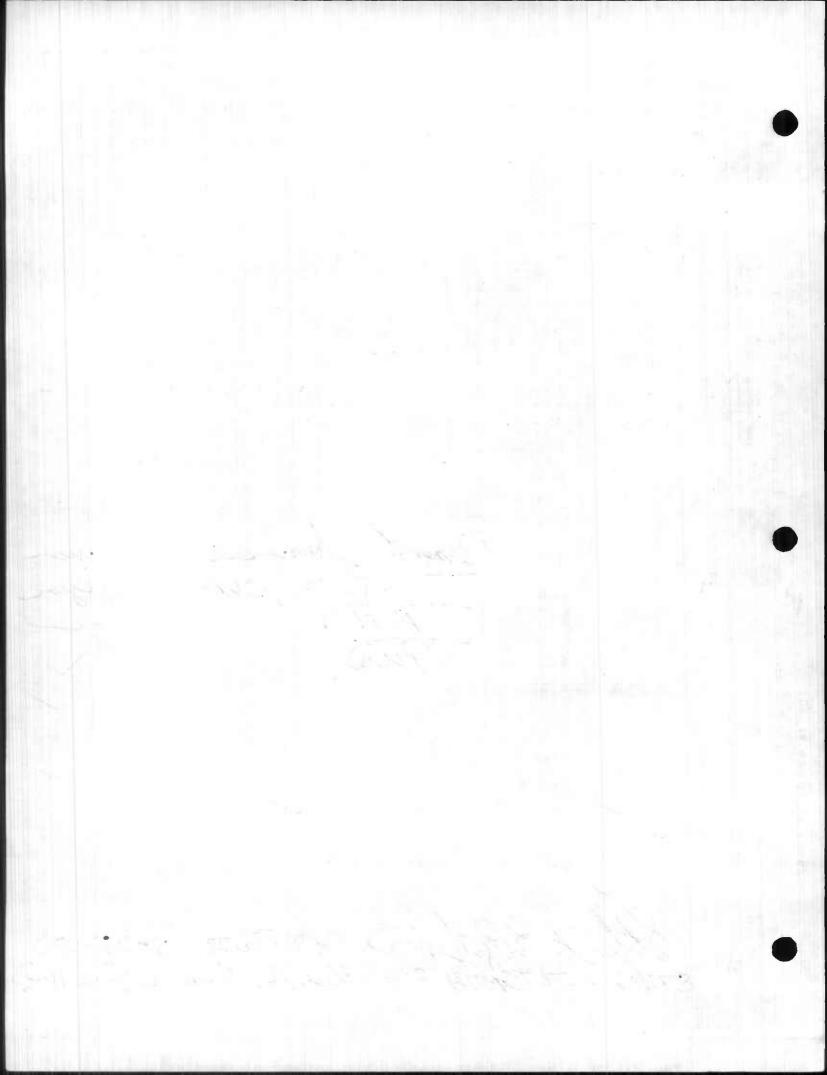
DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

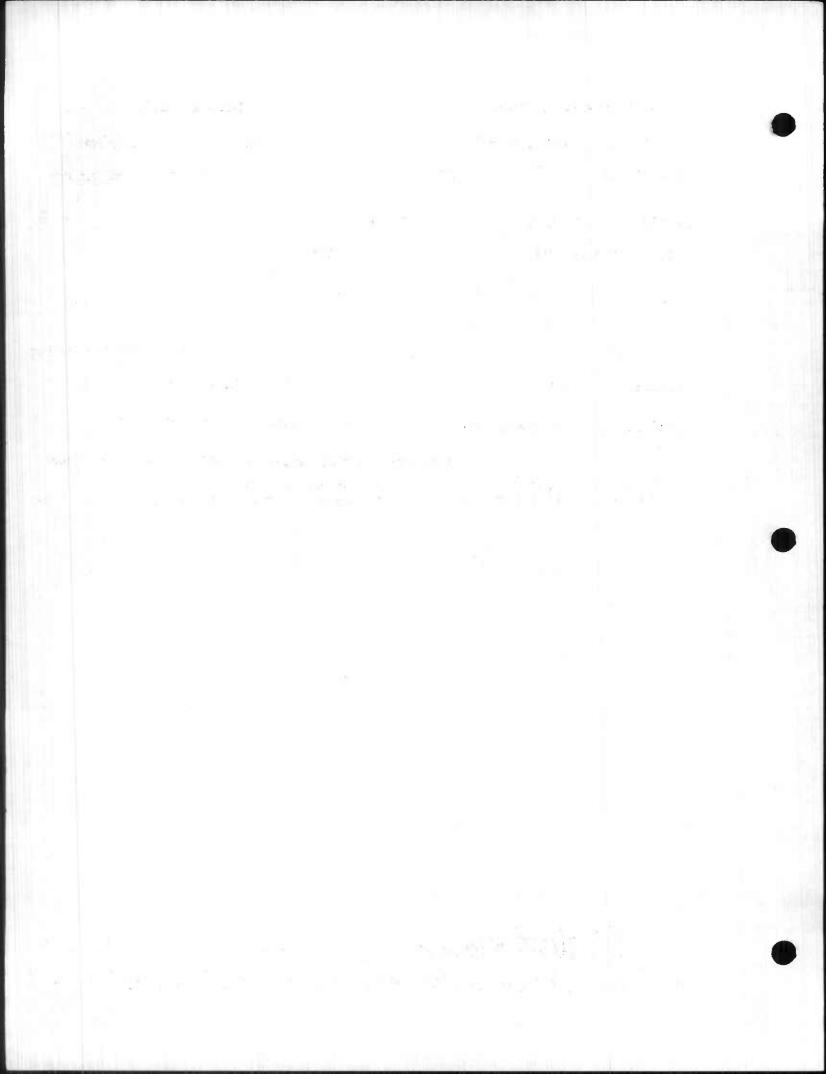
Physician //Medical Examiner  Gurnice Stephens Bowman  4e Facility Nama (If not institution, give street and number)  4c Facility Nama (If not institution, give street and number)  4db. City, Town, or Location of Death  4c. County of Deeth  4dc. County of Deeth  4	Time of Death 2:45 AM
Medical Examiner   Curnice Stephens Bowman   March 26 200   Stephens Bowman   March 200   Stephens Bowman   Marc	2:45 AM
Funeral Director    Citizens Natering Home   Have do Grace   Harfeet Harfeet	
Funeral Director  5. Social Security Number  222-09-6158  Usuel Residence of Decedent  5. Social Security Number  8. Sex 1 M 20XF  81  7. Age (In yrs. last birthday) 1 M 20XF  81  7. Age (In yrs. last birthday) 1 Months Days Hours Min.  9. Birthplace Country) 1 M 20XF  81  9. Birthplace Country) 1 Mary la	
Director   222-09-6158   81     08/06/1918   Maryla   Usuel Residence of Decedent	(State or Foreign
	and
5 34	Inside City Limits
MD Harford Havre de Grace	1 ☐ Yes 2 X No
the sea G	
1920 Chapel Road  11. Manitel Status  1 Never Married  21078  USA  11. Manitel Status  1 Never Married  1 Ne	ndian.
3 Wildowed 4 Divorced Year or Dates:  NYes, Give 1 Yes 2 No Specify: Specify: White	e
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	У
15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) 11th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  Home	
	3-2-30
17. Father's Neme (First, Middle, Last)  Hugh Ross Stephens  19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code  Sapplington Los Rowmans Husband 1920 Charol Rd Havyo de Grace NiD 21	
19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code	
ESSE I SZODINOTON LEE DOWNANT BUSOZNO 1770 CREDELING. HAVIE DE CLACE, MD 41	
1X Burial 2 Cremation 3 Removal from State	
4 Donation 5 Other (Specify) Wesleyan Chapel Cem. 3/29/00 Havre de Grace 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility	e, MD
	21070
	21078 proximste erval Between
Physician Onse	set end Death
/Medical Immediata Cause (Final disease or condition a. // / / / / / / / / / / / / / / / / /	year
Due to for as a consequence off.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	Jean
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	
Gause (Disease or Injury that initiated events resulting in death) Lest	
5 04 2	1
d. John Marian Clary Control of the	~
O o o o o o o o o o o o o o o o o o o o	
0 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	
24a. Wes an eutopsy performed?  24b. Were su aveilable complete of death	autopsy findings ble prior to etion of cause th?
1 Yes 2 W6 1 Yes	2 No
The state of Death (Check only one)  25. Was case referred to predical state of Death (Check only one)  25. Was case referred to predical state of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death (Check only one)  28. Date of Injury at 1 28d. Describe how injury occurred	
Hospital: 1 Inputient 2 ER/Outpetient 3 DOA Other: 4 Aurising Home 5 Residence 6 Other (Specify)	
28d. Describe how injury occurred work?  3 0 2 3 4 5 5 7 Accident investigation  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Natural 5 Pending (Month, Day Year)  M 1 Yes 2 No	
The first of the f	ute Number,
The state of the cause (s) and menner as steled.  200 Control of the cause (s) and menner as steled.  201 Market State of the cause (s) and menner as steled.  202 Market State of the cause (s) and menner as steled.	
and manner stated.  29c. License number 29d. Dete signed (Month, Day,	
1 20053622 3-27-	-00
100	
30. Name and address of person who completed care of death (Hern 23e) Type, Print) S Unit Are Hause & Grace  State 31. Dete filled (Month, Day, Year) 32. Registrar's Signature	e hus

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2000 March 26, Year **Physician** William Albert 1958 /Medical 4a. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Fallston General Hospital Fallston Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (Stete or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 10℃M 2□ F Yrs Director 138-03-2286 97 Feb. 16, 1903 New Jersey Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, the Modical Examiner must be notified as 1 ☐ Yes 2 No Director Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 W. Heather Rd. 21014 USA death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after of the of Health and Mental Hygiene.
nt: If Item 27 ie marked other than "natural", or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify. <u>م</u> 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 11 Residential Painting Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles P. Brown Clara L. Slaugh 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 108 W. Heather Rd., Bel Air, MD 21014 other t Carl Reightler / Son-In-Law 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetlon 3 □ Removal from Stete Injury or 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Grdns | 3-30-00 Fallston, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner herosc eros burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Last and Due to (or as a consequence of): physician at the burial Box 68760. Physician/Medicai Due to (or as a consequence of): ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. PO 23b. Did tobacco use contribute to the cause of death? signed by t 20 No 3 Probably 4 Unknown 1 ☐ Yes Records, þ pis need signature 24b. Were eutopsy findings available prior to Completed 24a. Was an autopay performed? completion of cause of death? hes this certificate 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2ER/Outpatient 3□ DOA 1 Yes 1 Inpatient funeral 28c. Injury at Work? Mariner of Death 28a. Date of Injury (Month, Dey Year) 20b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death Funeral Director; A 2 Aceident completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medicai To the Within 2 29b. Signature and the of cartifie 29c. License number 29d. Date signed (Month, Dey, Year) 2000 death (Item 23e) (Type, Print) #102 345 IVESS 31. Dete filed (Month, Dey, Year) 32. Bigistrer's Signature State MAR 28 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician** March 22, 9:30 pm 2000 Alicia Georgina Camacho

4a Facility Nama (If not institution, giva street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Circle Manor- Mariner Health Kensington
H Under 24 Hrs. 8.
Hours | Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 10M 20F Months Director 88 Apr 19, 1911 262-92-5588 Cuba Usual Rasidence of Deceden with the Maryland 10a. Stata r 28a-f ahow 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mart be 4521 East West Highway, Apt 1202

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? Funerai death 20814 USA Rems 2 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Peges 1 end 2 should be filled within 72 hours after de nent of Heelth end Mental Hygiene.
Int: If them 27 is marked other than "natural", or them lay or other treumatic event, the Medical Essentian. Black, Whita, atc. 1 Yas 2 No
If Yes, Give
Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 No Specify: by Cuban 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Juan J. Mignagaray Enriqueta Valdes Brito 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurat Routa Number, City or Town, Stata, Zip Code) Alicia C. Hoffman/ Daughter 909 Parsons Drive, Madison, MD 21648 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata Department of Important: If eny injury or pace. 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 3/24/00 Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensee 500 Univeristy Blvd., W, Silver Spring, MD 20901 Borres 23a. Part 1. Entar the disease, or complications that cause the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disease or injury that initiated events rasulting in death) Last use as the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical Due to (or as a consequance of): signed by the ald be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? page 2 should After this certificate has 1 ☐ Yes 2 0 No 1 ☐ Yas 2 ☐ No or Attending Physician: director, 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturat 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signad (Month, Day, Year) 00 30. Name and addrass of person who completed cause of death (item 23a) (Type, Print) TEANNE

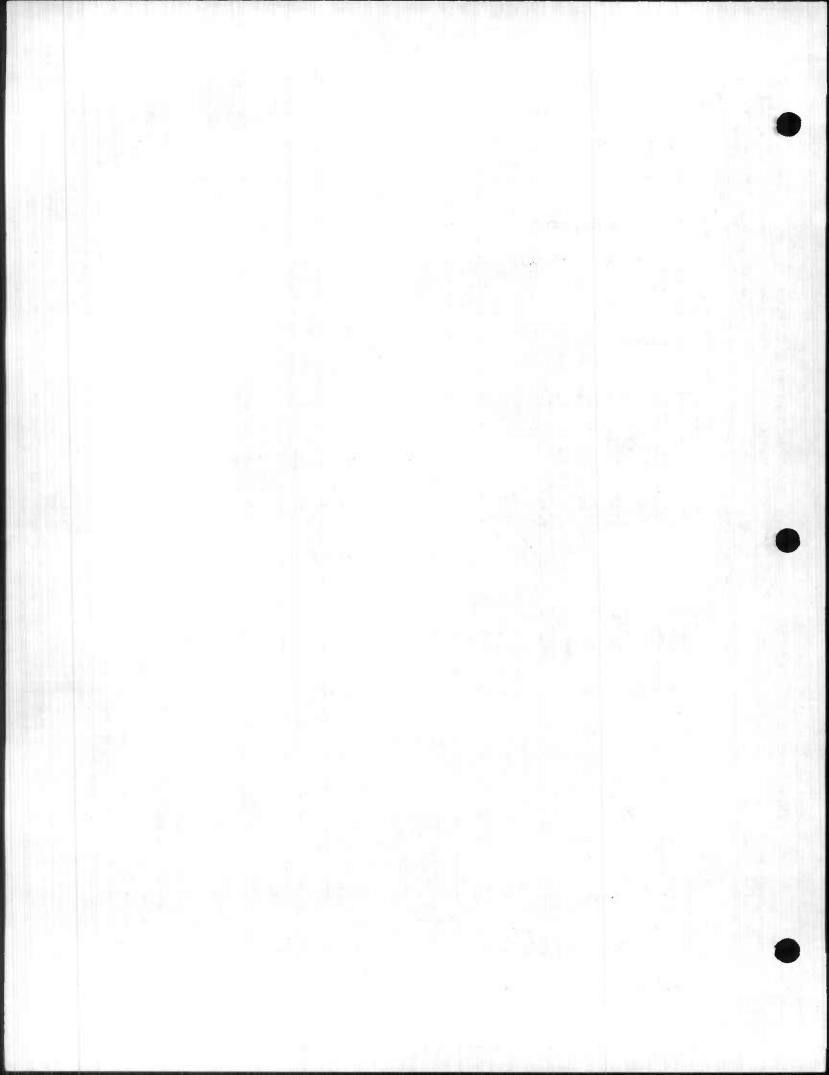
State Registrar 31. Data filed (Month, Day, Year)

MAR 27

2000

DHMH 16 Rev 6/95

32. Registrar's Signatura



## Pi

	Pleas	e Type or							II Copies Mental Hy		-	ible.	1700		
		State	n waryiai				f Death			gien Reg. N	0	)	1730		
1. Decedent's Nama (Firs	t, Middle,	Last)							2. Date of De	eth			3. Time of Deeth		
Gurbux D.	Chab	lani							Month March	25 D	<sup>y</sup> 200	Year	5:12 PM		
4a. Fecility Nama (If not in	nstitution,	giva street end nu	m <i>ber</i> )				4b. City, To	own, or L	ocation of Deet	-		y of Deeth	J.12 IM		
204 Montvale	Ter	race					Silve	r Sp	ring	M	onte	omery	,		
5. Social Security Number	r 6	S. Sex	7. Age (In yrs.	last birth		nder 1 Ya	ar If Under	24 Hrs.				9. Birth	piace (Stete or Foreign		
049-86-5175	5	1⊠M 2□ F	68	Yr	s. Mon	ths Dey	's Hours	Min.	April 12	19:		Cou	dia		
Usual Residence of Dece	dant										-	1 111	ula		
10a. Stete 10b.	County		10c. Ci	ty, Town o	or Location								10d. Inside City Limits		
Maryland Mo	ntgo	mery	Si	lver	Spri	ng							1 ☐ Yes 2 🕱 No		
10e. Street and Number						. Zip Code	)			10g. C	tizen of	What Cou	ntry?		
204 Montvale	Ter	race				20904	4			Unii	bo-	State	S		
11. Meritai Status		12. Was Dec	edent Ever in U	I,S.	13. Was D	ecedent o	f Hispenic Or	lgin? (Sr	ecify Yes or No	-			can Indien,		
1 Navar Married 2	Married	Armed Fo	orces?		if Yes,	specify Cu	ıban, Mexicai	n, Puàrto	Rican, etc.)			ck, White,			
3 ☐ Widowed 4 ☐ Divorcad Yaar or Detes:					1 ☐ Yes 2 ☑ No Specify: Specify:							y: Ind:	Indian		
15. Decedent's Education 16a. Decedant's Usuel Occupation (Specify only highest grede complated) (Give kind of work done during most of working								f Business/Industry							
Elementary/Secondery	1	life. DO NOT use retired)													
12		College (			Ban	ker					Ban	king			
17. Father's Nama (First, I	Middle, La	st)					18. Motha	ar's Nam	e (First, Middle	, Meide	Sumer	ne)			
Daryanoma1	Cha	blani					Gopi	Ad	vani						
19a. Informant's Name/Re	elationship	(Type, Print)		19b. N	Aailing Add	ress (Stre	et end Numb	er or Rui	ral Route Numb	er, City	or Town	, Stete, Zip	Code)		
Nirmla G. Ch	abla:	ni/ Wife		204	Mont	vale	Terra	ce.	Silver	Spri	no.	MD 2	0904		
20a. Method of Disposition 1 Durial 2 CCren 4 Donation 5 D	nation 3		State	Placa of D cemetery,	isposition cremetory ry Cre	(Name of or other p	/eca)	I	Data March 26,	20c. L	ocation	- City or To	own, Steta		
21. Signeture of Funeral S		-	\mu_0068		22. Nam	e end Add	ress of Facili	v Ro Cha	bert A.	Pun 75	phr	ey Fu	neral Home		
angue or hear failur	ese, or co re. List on	mplications thet only one cause on e	eaused the deat each line.	th. Do not	t enter the	moda of d	ylng, such es	cardiec	or raspiratory e	rrest,			Approximata Interval Between Onset and Death		
Immediate Ceusa (Final diseasa or condition		A Aspi	ration	Pneu	monia								10 Days		
resulting In deeth)		0			nsequence	of):							To Days		
												1			
Sequentielly list conditions	s.	b	Due to (d	or as a cor	nsequence	of):						-			
if eny, leeding to immedie cause. Enter Underlying	te											i			
Ceuse (Disease or Injury that initiated evants	<	C	Due to (c	r ec e cor	sequençe	of).									
resulting In daeth) Lest			Due 10 (0	. es a col	-204401108	vij.						1			
		d													
Part II. Othar elgnificant c	onditiona	contributing to de	eath but not ras	ulting In th	ne undarlyl	ng cause	given in Part I	l.	23b. Dtd	tobacco	use co	ntributa to	the cause of death?		
Spinal Mus					,				10	Yes 2	No No	3 Pro	bably 4 Unknow		
		-							24e. Wes	an auto	psy	24b. W	are eutopsy findings		

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is merked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Evantmet must be notified at once.

Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Director

Funeral

þ

Completed

Be

**Examiner** 

**Funeral** Director

Examiner	Sit
an/Medical	Si de Ci ce
Physici	Pa
by	120
ication: To Be Completed by Physician/Medical Examine	-
Be	25
10	
ication:	27

To the Hospital or Attending Physician: The lew requires that the death certificete be executed within 42 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely lilled in by the funeral director, page 2 should be detached for use as the burtansit Medical Certif

Division of VItal Records, P.O. Box 68760,

any	d								
SIC	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part								
Ē	Spinal Muscular Dystrophy								

thar significant conditiona contributing to death but not rasulting in the undarlying cause given in Part I.	23b. Did tobacco use co	entributa to the cause of death
inal Muscular Dystrophy	1 ☐ Yes 2 ☑ No	3 Probably 4 Unknow
	24e. Wes an autopsy performed?	24b. Ware eutopsy findings avelleble prior to completion of cause of daath?
	104	.6

							24e. Wes an autopsy performed?	24b. Ware eutopsy findings aveileble prior to completion of cause of daath?  1 \( \text{Yas} \) 2 \( \text{No} \) No	
25.	Was casa referre	ed to medical				26. Placa of D	eath (Check only one)		
	1 ☐ Yes 2 ☑ !	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Homa 5 N Residenca 6 □ Other (Specify)			
	Manner of Death 1 ☑Naturel 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	28c	. Injury at Work?	28d. Describe how Injury occur		
	3 ☐ Suicida 4 ☐ Homicida	6 Could not be determined		nome, farm, stree	t, factory, o	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			
29	a. Cartifier	1 CertifyIng Ph	ysictan: To the best of my kno	owledga, death o	occurred at	tha tima, data end plac	ce, end dua to tha causa(s) and ma	annar as stated.	

D35941

March 25, 2000

29a. Cartifier (Check only one)	2 Madical Examiner:	n: To the best of my knowledga, death occurred at tha tima, data end place, On the basis of examination end/or investigation, in my opinion, death occurred manner statad.	end dua to tha causa(s) and mannar as stated. red at tha time, date and placa, and due to tha causa(s)
29b. Signeture an	d titla of cartifier	29c. Licanse number	29d. Dete signed (Month. Dev. Year)

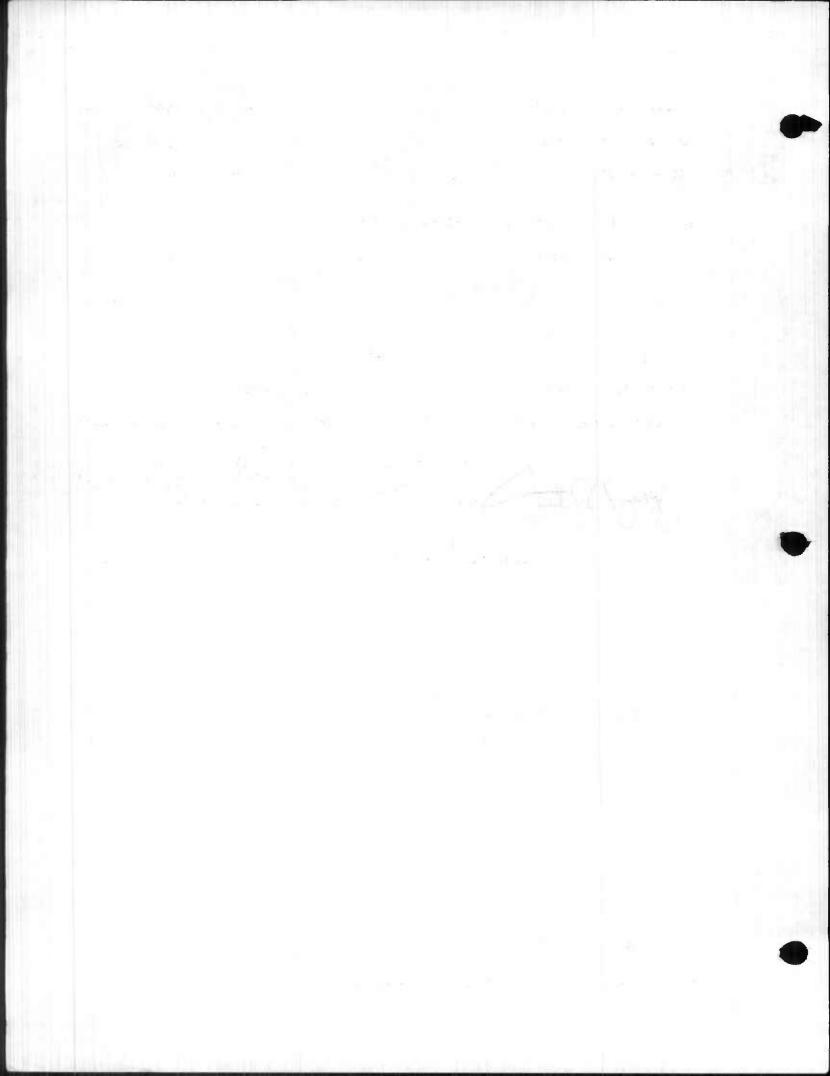
30. Name end address of person who complated cause of death (Item 23e) (Type, Print)

MAR 2 7 2000

Puran P. Mathur, M.D. 50 W. Edmonston Drive, #401, Rockville, MD 20852 31. Date filed (Month, Day, Year)

State Registrar 32. Pogistrar's Signature

5



SHUI

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death

- 1		7		- 1
- 1		1	-4	- 1
	-1	- /	U	- 6

CHI	NG
7	Physician /Medical Examiner

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infortant: If item 27 is marked other than "natural", or itema 23a or 28a-f show any fully or other traumatic event, the Medical Examination and profiled applies. Not the traumatic event, the Medical Examination and profiled applies. Not Baltimore, Maryland 21215-0020 Physician

Examine To the Hospital or Attending Physician: The law requires that the deeth certificate be execute within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneat director, page 2 should be detached for use as the builai-trans Division of Vital Records, P.O. Box 68760,

/Medica

Decedent's Nar	ne (First, Middle, La	st)							2. Date of Dea	Day	Year	3. Tima of Death
Shui Ch	ing Chung								MARCH	27,200	00	11:35A.M.
4a Facility Name	(If not Institution, glv	re street and numb	er)				4b. City, To	wn, or L	ocation of Death	4c. County	of Death	
	EORGES CO						CHEV			PRINCE		
5. Social Security 05462410		Sex 7. □ M 280 F	Age (In yrs. I	ast birthda Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day July 2	(Voor)	9. Birth	plece (State or Foreigr Intry) LNA
Usual Residence			140.00									
10e. State	10b. County		10c. City	, Town or	Location							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
TX 10e. Street and No	Harris umber		Hous	ston	10f. Zip	Code				10g. Citizen of V		
12853 R	riar West				770	77						
11. Marital Status	ITAL WEST	12. Was Decede	nt Ever in U,	S. 1			lispanic Ori	gin? (Sp	pecify Yes or No-	14. Rac		ican Indien,
	rried 2 Married	No						Speci			fy: Chilana	
3 CJ WIGOWEG	15. Decedent's E	Year or Date	is:	16a Dec	cedent's Usua	il Occur	nation			16b. Kind of Bu		Inese
	cify only highest gra	ide completed)		(Gi	ve kind of wor	rk done	during mos	t of work	king	TOO. TURO OF O	1000011	locotry
Elementary/Sec	condary (0-12)	College (1-4	or 5+)		rietor					Restaur	ant	
	(First, Middle, Last			# 1 O P	110001		18. Mothe	er's Nam	e (First, Middle,			
Da Wai	Man						Li	7.h	ano			
	Name/Relationship	Type, Print)		19b. Ma	ailing Address	(Street			ral Route Numbe	r, City or Town,	State, Zi	ip Code)
	Chung/Son				Myrick							
20a. Method of Di			20b. Pt	ace of Dis	sposition /Nan	ne of	ÜKI		Date	20c. Location -	City or T	own, State
	Cremation 3X 5 Other (Special		ete Ce	emetery, c	rematory or o	tner pia	ice)	-	222222			
	uneral Senuce Licer				22. Name an	d Addre	es of Facili		33020001			
) z]	111 -	1						30	seph Gar			OC 20016
23a, Part1, Enter	the disease or comert failure. List only	plications that cau	sed the death	n. Do not e								Approximate
shock, or he	art failure Jist only	one cause on eac	h line.					>			i	Onset and Death
Immediate Cause		1	1/10	0+	-06		Î	n	jur	291	1	
disease or conditi resulting in death	on )	a	viu	1	17	_				103	1	
			Due to (or	ras a cons	sequence of):				7		1	
Sequentially fist of	anditions C	b	Due to (or	as a cons	sequence of):							
if any, leading to i	immediate		200 10 (0.	40 4 0011	304001100 017.							
if any, leading to i cause. Enter Unc Cause (Disease of that initiated even	or Injury its	C	Due to (or	as a cons	sequence of):						-	
resulting in death)	) Last		Due 10 (01	as a cons	isqualice of).						1	
		d										
Part # Other elen	iffcant conditions of	contribution to don't	h but not resu	itting in the	underhina e	ausa oi	uon in Part		23h Did	obacco usa co	ntribute	to the cause of death
rait ii. Other sign	incam conditions o	onthouring to deat	n but not rest	atting in the	a underlying c	ause gr	Ven HI Fait		10			obably 4 Unknow
										2 2 2 110	0011	obably 4 dinate
									24a. Was	an autopsy	24b. V	Vere autopsy findings
									perfo	rmed?	C	vailable prior to completion of cause of death?
									100	res 2 No	1	Yes 2 No
25. Was case refe axaminer?		Hospitel:				Ot	hor:		th (Check only o			
1 ∑ Yes 2 ☐ 27. Menner of Dea		1X Inp		28b. Time	tient 3 DC	JA	4 L N	ursing H	ome 5 Resid	tence 6 LIOth		oify)
1 Detural	5 Pending	(Month)		Injur		8c. Inju	rk? Yes 2	No	Parien	ger o	Fin	eter rehic!
2 Accident 3 Suicide	investigatio	2/01	700		ZAM			110	thet stru	ek tined	06	ral Route Number,
4 Homicide		200 Ft 1000 OI	ota (Specify	me, farm,	street, factory	, onice	25 -	117	City or To	p, State)	1	1/1/1
		STR	2	,	. 12	11	CTIC	16	Be	ITSV1/	10,	rola.
29a. Certifier (Check only one)	1☐ Certifying Pt 2X Medical Exar	ysician: To the be niner: On the basi and manner	s of examinat	viedge, de ion end/or	ath occurred investigation	t the ti	ime, date ar opinion, dea	nd place ith occu	, and due to the rred et the time,	cause(s) and ma date and place,	anner as and due	stated. to the cause(s)
29b. Signature an	d tige of certifier	2	1	1	290	. Licen	se number			29d. Date signe	d (Month	n, Day, Year)
1	(D) -	0.11.1	11	1)								
- 4	11111	uner	_ //	-1	0.10	(	). C.M.	F	M	ARCH 28	.200	()

State Registrar

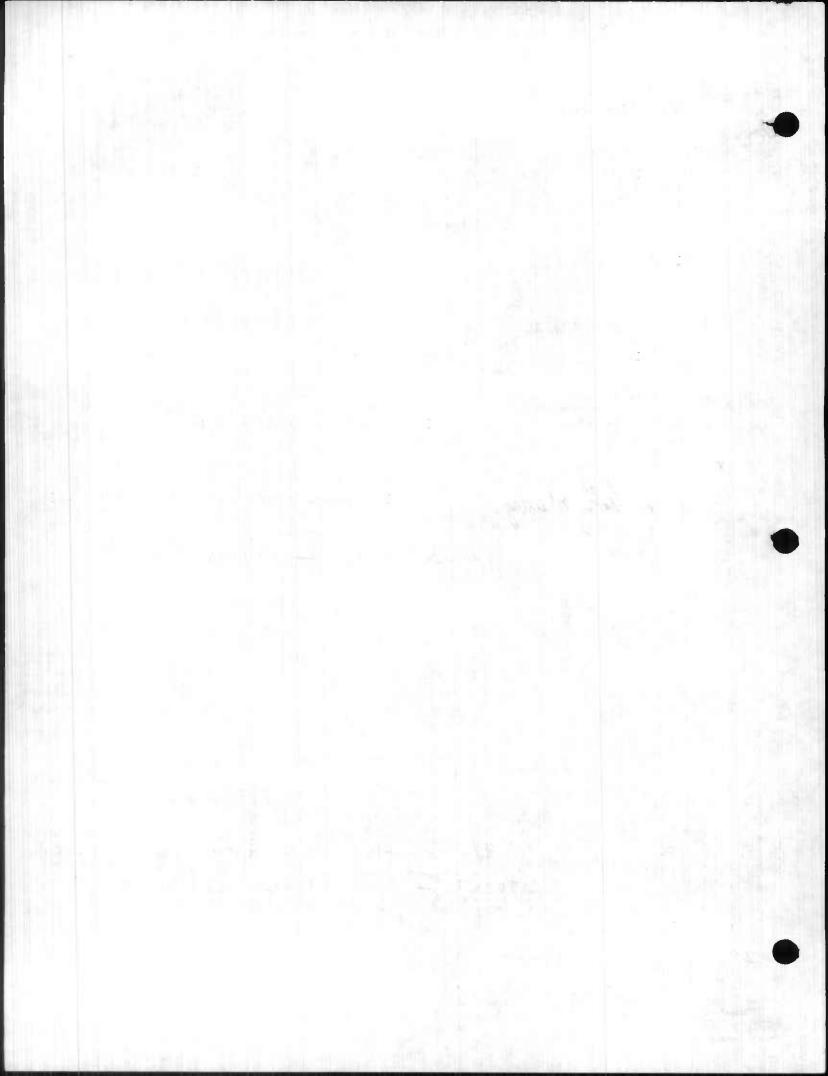
111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

estaner

32. Registrar's Signature

31. Date liled (Month, Day, Yell) MAR 3 1



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 732 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hugh Duffey Clark 23 10:15 am March 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 23614 Clarborne 5. Sociel Security Number Talbot Clouborne If Under 24 Hrs. Landing Road 6. Sex 1 M M 2 ☐ F If Under 1 Ye 7. Age (in yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Hours Min. Months Days 217-30-0478 Director Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Funeral Director Talbot MD Clayborne 10a. Street and Number 23014 Clotborne Landing Road 11. Meritel Stetus 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Married 1 Never Merried 2 No If Yes, Give Year or Detes: 1953 - 56 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21624 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No Specify Completed by White Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Soupment House Building 12 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If fem 27 is marked oths any Injury or other traumatic avent place. 17. Father's Name (First, Middle, Last) Be Oscar Hugh Duffey Clark 19e. Informent's Nemerhelettonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23014 Claiborne Landing Rd. Clayborne, MD 21624 Nancy Clark Ispouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete Gift Foundation 3124/00 5 Other (Specify) Laurel, MD 21. Signetyle of Funerel Service License 22. Neme end Address of Fecility Anatomic Gift Foundation 13948 Baltimore Avenue Laurel, MD 20707 At. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, ock, or heert tellure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** HOENOCARCINOMA RENAL CEL /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or es a consequenca ot): Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or es e consequence of). Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Trong Onknown py 24b. Were autopsy findings available prior to completion of cause of death? RTENSION Completed 24a. Wes an sutopsy performed? 2/2No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Panding investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician: after death. Director: After this certific To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

28a-f show

5 238

Hems 2

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director.

funeral

4 Homicide

29b. Signeture and title of certifier

29a. Certifier (Check only one)

Hygiena.

filed within 72 hours after

Maryland 21215-0020

Baltimore,

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State Registrar

29c. License number

29d. Dete signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

26350

12000

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. William S. Bremmer, M.D. 800 S. Talbot Street St. Michaels, MD 21663

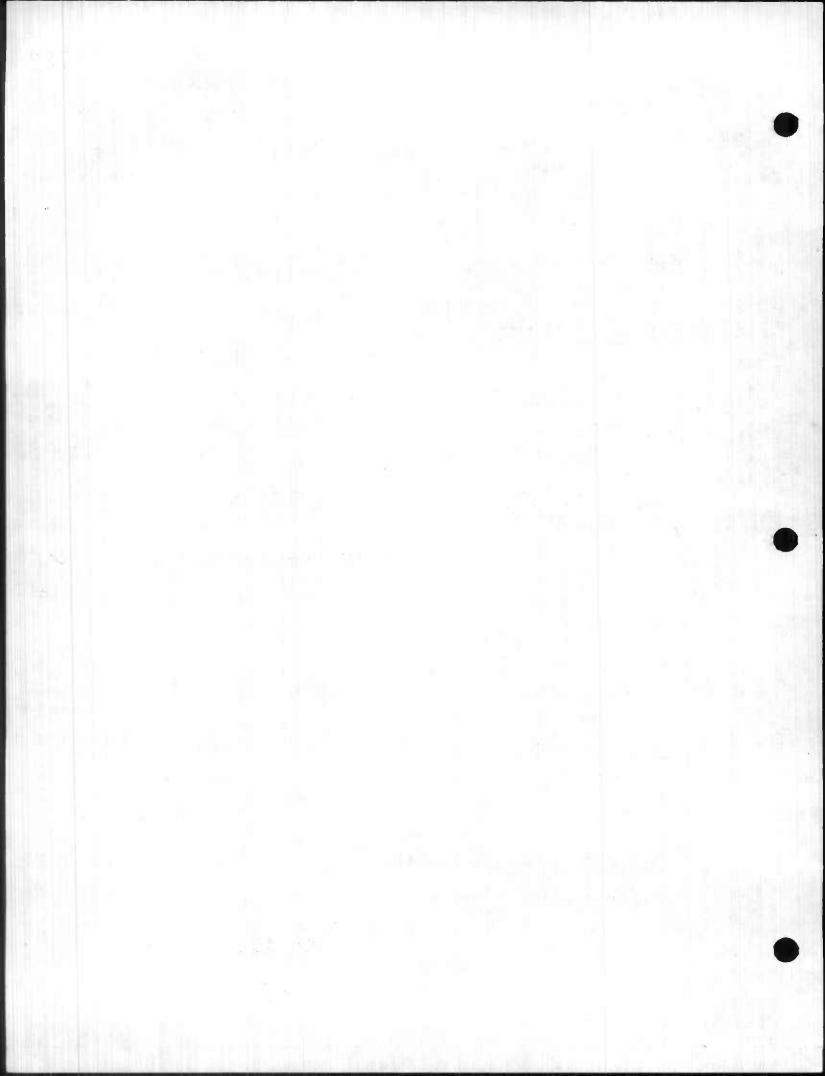
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year) MAR 28

32. Registrer's Signeture Senera

1년 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

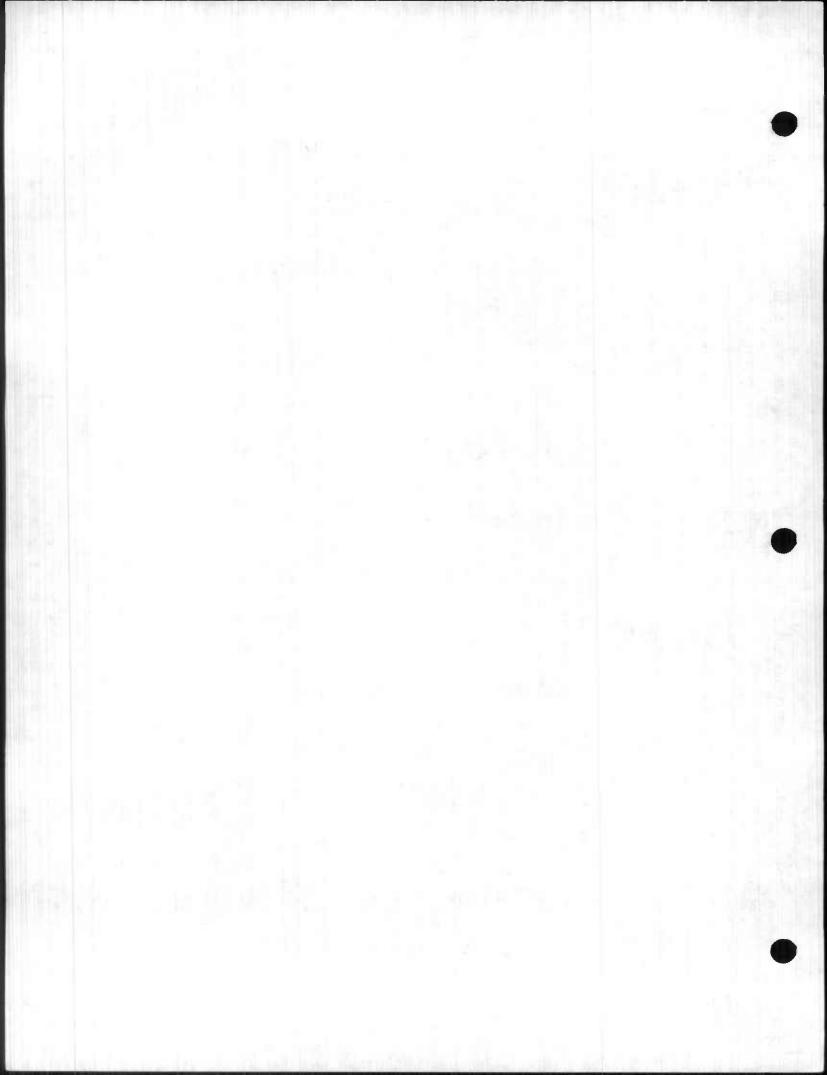


State of Maryland / Department of Health and Mental Hygiene

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					Certific	ate of	Death			Reg. No.			
	1. Decedent's Na	ame (First, Middle, Li					Date of Death 3. Time of De						
Physician /Medical	MILTON (	CLAR  (If not institution, gir		4h City To	own or Lo	Month MARCH cation of Deat	24, 20	Year OO nty of Death	5:20 PM				
Examiner									CallOIT OF DOG				
	MONTGOM  5. Social Security		AL HOSPITA	L ge (In yrs. lest birl	hdoul If Ur	nder 1 Yeer	OLNEY If Under		8. Date of Bir		GOMER'		
Funeral Director	579.12.	9324	Sex 7. Ag		79 Yrs. Months Day			Min.	(Month Di	y, Year) 1, 1920	Cou	Birthplace (State or Foreign Country) ASHINGTON, DC	
P ,	Usual Residence	of Decedent 10b. County		10c. City, Town	or Lagation						10d. Inside City Limits		
vith the Maryler or 28a-f show		MONTGOME	ERY	SILVER	iG					1 ∑ Yes 2 □ No			
or 28	10e. Street and i	Number			10f. Zip Code					10g. Citizen of What Country?			
th will		OMECREST I	ROAD #511		USA								
fler death v	11. Maritel Statu	s	12. Was Decedent Armed Forces		ver in U,S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerlo					)- 14. R	ace - Ameri		
by by	3 ☐ Widowed	erried 2 Married	1 Yes 2 X If Yes, Give Yeer or Dates:		s 2 No			1110011, 010.7	Spec	HITE			
21215-0020 ed within 72 hours af ggiene. er than "natural", or ft, the Medical Exert Completed by F	(St	15. Decedent's E	ducetion ade completed)	16a.	Decedent's U	Jsual Occu	pation during mos	st of worki	in <i>a</i>	16b. Kind of			
dithin new	Elementary/Se	econdary (0-12)		College (1-4or 5+)			id)					MECHANICAL	
nd 212 filed within other than vent, the M		12		IN	INVENTOR/EN			GINEER/DESIGNER			EER		
Maryland 212 d 2 should be filed with th end Mentel Hygiens. 7 is marked other that traumatic event, tre.) To Be Comi		ne <i>(First, Midd</i> le, Lasi N CLAR		18. Mother's Name (First, Middle, Maiden Sumame) FANNIE FEINSTEIN									
Aar 2 sh 2 sh 1 end 1 end	19a. Informant's	Name/Relationship	(Type, Print)							er, City or Tow LLVER S			
Baltimore, N Deamit. Peges 1 and 3 Department of Health Important: If Hem 27 I any Injury or other tr and once.	20a. Method of D		Removel from State	cometer	20b. Place of Disposition (Name of cemetery, cremetory or other place)  MAT					Date 20c. Location - City or Town, Stete			
T S S E L		n 5 Other (Speci			N MEMO	RIAL	GARDE		6, 2000	OLNE	Y, MA	RYLAND	
Baltimo pemit. Peg Department Important: If any Injury o	21. Signature of	Funeral Harvice Lice	nsee				ess of Facil		T DIDEV	TONI T	NC		
<b>0</b> 88 E 2 8	EDWARD SAGEL FUNERAL DIRECTION, INC.  1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852												
Physician /Medical	23a. Part1. Enter shock, or h Immediate Caus disease or cond	eart tailure. List only se (Final	plications that ceuse one cause on each t	d the death. Do r ine. GENIC SH		node ot dy	ng, such as	s cerdiac o	or respiratory a	arrest,	1	Approximate Interval Between Onset end Death	
Examiner	resulting in deat	h)	a	Due to (or es a d		of):							
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58760, icate be assocuted physician and s the burial-transit edical Examin	Sequentially list	conditions,	Due to (or as e consequence of):										
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E 00 =	resulting in deat	h) Last	Due to (or es e consequence of):								1		
that the death certification to the death of the attending to detached for use as physician/Me			d										
et the death of the death of the death of the attended for us.	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause							e given in Part I. 23b. Did tobacco use contribute to the cause					
	DIABETE	DIABETES MELLITIS							1 Yes 2			No 3 Probably 4 ™ Unknown	
Cord v requir been s should	RENAL FAILURE, CHRONIC									erformed? available complete		Vere eutopsy findings vailable prior to ompletion of cause f death?	
									10	Yes 2X No	1	☐ Yes 2☐ No	
Vital sicien: The certificate irector, pe		ferred to medical	1				26. Plac	e of Deat	h (Check only	one)			
		The state of the s	Hospital:	ent 2□ÆR/Ou	toatient 3	DOA O	her:			idence 6 🗆 (	Other (Spec	i(v)	
Jing Phy Jing Phy After thi funeral		sath 5 Pending	28a. Date of Inju (Month, De	ury 28b. 7	Time of 28c. In		njury at Work?		28d. Describe how injury occurred			<i>"</i>	
Division of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	2 Acciden 3 Suicide 4 Homicid	Suicide 6 Could not be		lace of Injury - At home, farm, street, factory, office ullding, etc. (Specify)					28f. Location (Street end Number or Rural Route Number, City or Town, Stete)				
Hospi 24 hou Funer stely fill			nysicien: To the best miner: On the basis o and menner si	f examination and									
within X											Day, Year)		
12	) Jelles 11 119							1921 MARCH 27, 2000					
Law policy	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)												
	JOHN A. 31. Date filed (M			POOKS H	ILL_RO	AD, B	ETHES	DA, N	1D 208	14			
State		MAD Q n 2	100	ar s Signature	4	-	,						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-1647-031 State of Maryland / Department of Health and Mental Hygiene \( \int \) Jane Cochrane Certificate of Death JVW 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month **Physician** March 22,2000 Cochrane Jane Ann 4:17 P.M. /Medical 4b. City, Town, or Location of Death 4e Facility Nema (If not Institution, give street and number) 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Sep. 28, 1933 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕮 F 66 Yrs. 577-44-2714 Maryland **Director** Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 the Medical Examiner must be 238 13611 Glen Mill Road 20850 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. or items 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: à White 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) Cottege (1-4or 5+) Elementary/Se Office Clerk Telephone Company 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be should be nd Mental is marked Robert James Cochrane Ruth Irene Hartman yes I and 2 sty, result and 2 sty, important of Health and h important if hen 27 is mark any injury or other. 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2.0882 19a. tnformant's Name/Reletionship (Type, Print) Ellen C. German / Sister 8632 Hawkins Creamery Rd., Gaithersburg, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from State Gate of Heaven Cem. 03/27/00 Silver Spring, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of FacilityHines-Rinaldi Funeral Home 11800 New Hampshire Avenue 21. Signature of Funeral Service Licens Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequ Examine sician and burial-trans Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): ettending physician for use es the buria 68760 Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use Contributs to the cause of death? deteched the 1 Yes 2 No 3 Probably 4 Unknown signed by by Division of Vital Records. 8 24a. Wes an autopsy 24b. Were autopsy findings available prior to completion of cause of death? Po Po Complet 1 Yes 2 No 2 No 25. Wes case referred to medicel Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 this 28d. Describe how injury occurred for Vehicle 27. Manner of Death Date of Injury 28b. Time of Certification: After 5 Pending investigation Attending 1 Neturet investigation

6 Could not be determined

2 Place of Injury - At home, ferm, street, factory, office building etc. (Specify)

1 Yes 2 No

Confidence of Number or Rural Route Number, Carry or Taym, Stele)

28f. Location (Street end Number or Rural Route Number, Carry or Taym, Stele)

28f. Location (Street end Number or Rural Route Number, Carry or Taym, Stele)

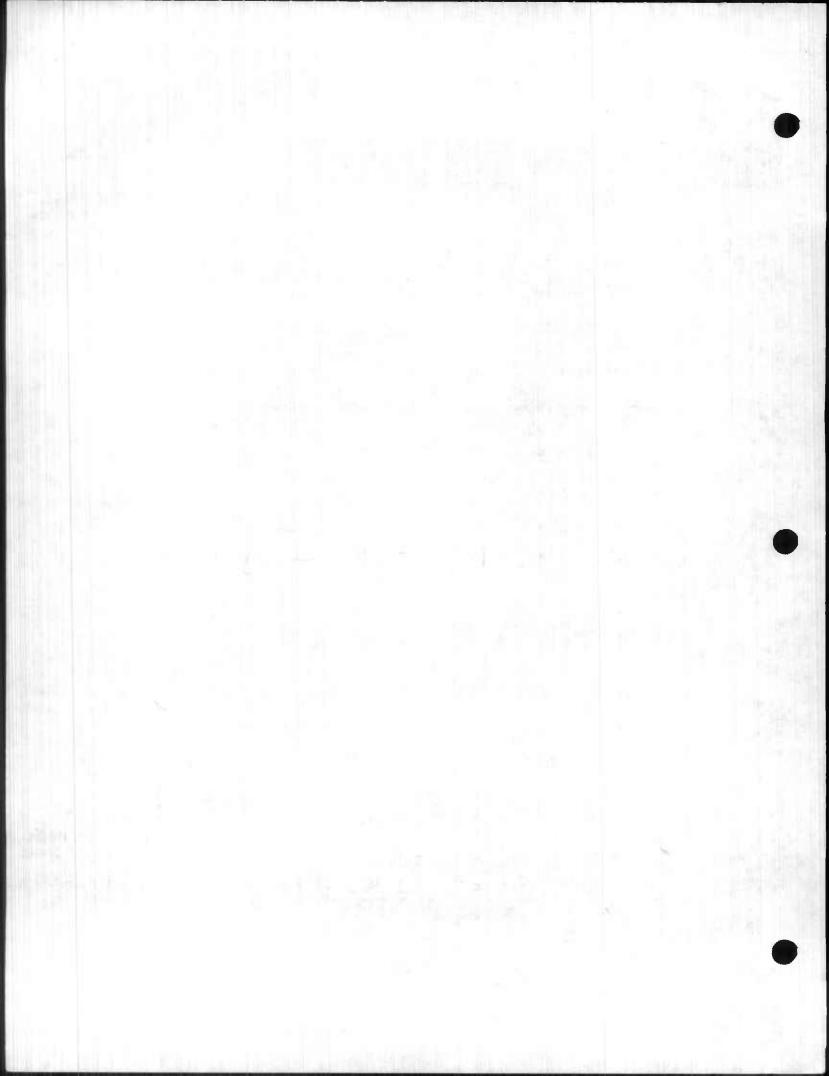
1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner estated.

29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) Injury death. with another vehicle 2 Accident after death Director: 3 Suicide 4 Homicide Montgomery Couty, Al To the Hospital of within 24 hours af To the Funeral D Completely filled In 29e. Certifier edical 29c, License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie O.C.M.E. March 23,2000 35 completed cause of death (Item 23a) (Type, Print) Estaner Pay, Year) 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, 32. Registrar's Signeture State

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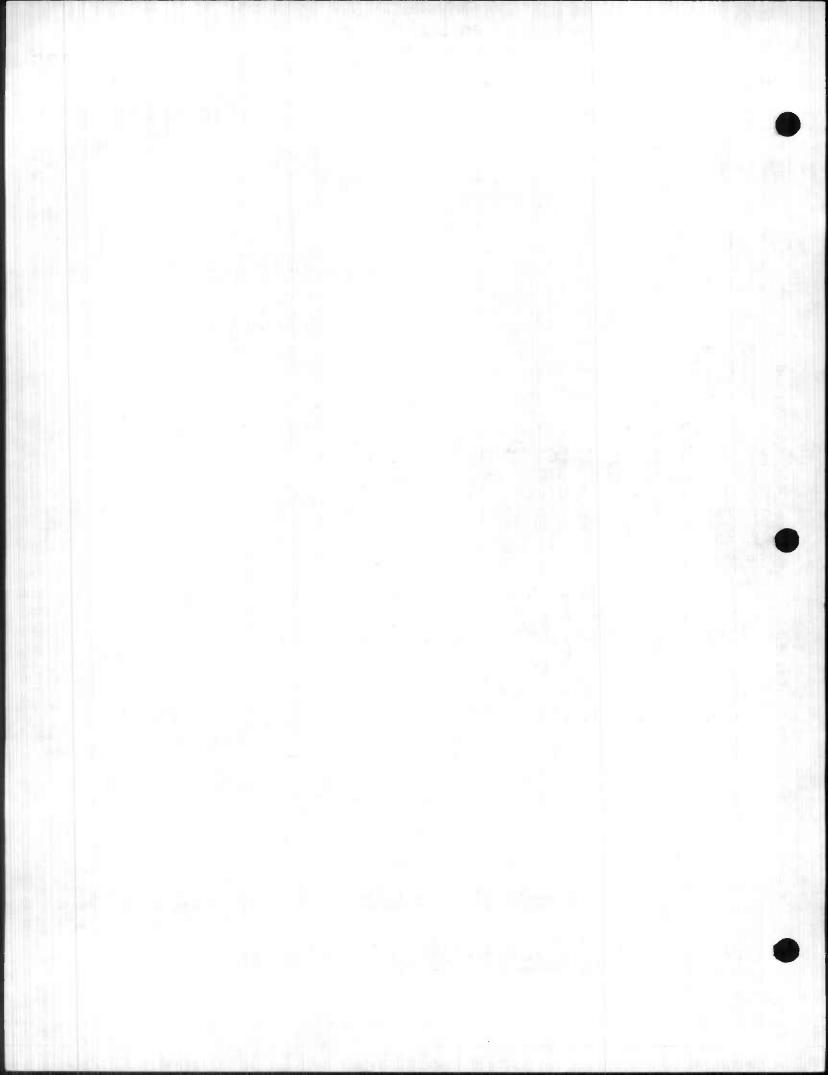
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MAR 28



State of Maryland / Department of Health and Mental Hygiene

							Certificate	e of	Death		Reg. No.	0	11735
		1. Decedent's Name (I	First, Middle, La	st)				-		2. Dete of Dec	eth	Vaar	3. Time of Death
Physic /Medi		Robert S.	Custer							Month	Day H 26 2	Yeer	7:070m
Exami		4e Facility Neme (If no		e street and nun	nber)				4b. City, Town, or L				-
		Washington	Advent	ist Hos	pital		N-TRIL		Takoma Pa		Montg	omery	
Funeral		5. Social Security Num	1	ex EMM 2□ F	7. Age (In yrs		hday) If Under Months			(Month, Day	(, Year)	9. Birthpli Count	aca (State or Foreign try)
Director	- 1	Usuel Residence of De	+/		80		115.			Apr 3,	1919	Maryl	and
Mend Mend			Ob. County		10c. C	ity, Town	or Location					10	Od. Inside City Limits
Men.	to	Maryland M	ionteome	rv	Si	1ver	Spring						1 ☐ Yes 2X No
7 28u	Director	10e. Street and Number			1 52	1101	10f. Zip	Code			10g. Citizen of V	Vhat Count	iry?
th wit	a D	807 Malcol	m Drive				209	901			USA		
r dea	Funeral	11. Merital Status		12. Was Dece Armed For		U,S.	13. Was Deced	lent of h	Hispanic Origin? (Spen, Mexican, Puert	pecify Yes or No-		e - America ck, White, e	
20 safts	by Fu	1 Never Married	177	1 X Yes If Yes, Giv	e 19	42-			Specify:			Whit	
21215-0020 d within 72 hours after death with the Meryland giene. rr then "natural", or herra 23a or 28a-f ahow the Medical Everyher result be intified as		3 ☐ Widowed 4 ☐	. Decedent's Ed	Year or Da	ites: 19	46	Decedent's Usua	I Occur	nation		16b. Kind of Bu		
	Completed	(Specify	only highest gra	ide completed)		104.	(Give kind of wor tite. DO NOT us	rk done	during most of wor	king	100. Killu bi bi	13111623/11/01	ustry
2121 d within piene.	E O	Elementery/Seconda	ary (0-12)	College (1 5+	-4or 5+)	Tra	ining /	Mar	keting		Privat		
d the	Be C	17. Fether's Name (Fir	st, Middle, Last)						18. Mother's Nen	ne (First, Middle,	Maiden Sumam	10)	
should be nd Mental marked o	To	Harold S.	Custer						Eleanor	Emelia	Achterm	ann	
Maryiand d2 should be file th end Mental Hy 7 Is marked oth treumatic event		19e. Informent's Name	/Relationship	Type, Print)		19b.	Mailing Address	(Street	t and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)
EENL		Monica Peg		er / Wi	fe	80	7 Malco	lm I	Prive, Si				
O S T S S S S S S S S S S S S S S S S S		20a. Method of Dispos 1 ☐ Burial 2 🛱 0		Bernoval from S		Place of cemetery	Disposition (Nan , crematory or o	ne of ther pia		Date	20c. Location -		
Pages mant of Pages land: If the luny or of		4 □ Donation 5 [			Me	trop	olitan (			3/31/00			VA
Baltimore, permit. Pages 1 at Department of Hee Important: If Nem any Injury or othe page.		21. Signeture of Funer	al Service Licen	1500			Francis	d Addre	collins	Funeral	Home,	Inc.	
20240		Stev	nO0	trord			500 Un:	iver	sity Blv	d., W, S	ilver S		, MD 20901
		23a. Part1. Enter the c shock, or heart fa	disease, or compailure. List only	plications that ca one cause on e	aused the dee ech line.	th. Don	ot enter the mode	e of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Deeth
Physician / Medical		Immediate Cause /Fin	al			0							Onset and Deeth
Examiner		Immediate Cause (Fin disease or condition resulting in death)	di	a.My	ocar.	SIA	- 1K	FA	RCTION	<u> </u>			
DECT .	ē			1	Due to	or as a c	onsequence of):		Dise				
Deta Insit	edical Examiner			b. COK	ONAN	4	ARTE	ry	1150	ASC		1	
exection and institute institute	Exa	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ions, ediate										
68760, tilicate be executed g physician and as the burial-transit	Cal	that initiated events		c.HRI	Due to	05 C	onsequence of):	012				-	
0 E 0 E	-	resulting in death) Las					,						
BOX Bath cert attendin for use	and			d								1	
i Records, P.O. Box The lew requires that tha death cer ate has been signed by the attendir page 2 should be detached for use	by Physician/N	Part II. Other significa	nt conditions c	ontributing to de	ath but not re	sulting in	the underlying ca	ause gi	ven in Pert I.	23b. Dld 1	obacco use co	ntributa to	the cause of death?
P.O.	F	Diag	ETES							10	as 21 No	3 Prob	ably 4 Unknown
Signe t be of	by	21412	2/02									T 0.41 11/-	A Ai Ai
Per need hould	Completed										an autopsy med?	ava	re sutopsy findings hilable prior to hipletion of cause
Hes the pe 2 s	du											of d	npletion of cause leath?
	3									101	es 20 No	1	Yes 2 No
Vitai itclen: T centificat rector, p	Be	25. Was case referred examiner?	to medical	Hospital:				Ott	26. Place of Dea				
Phys ral di	. To	1 ☐ Yes 2 No 27. Manner of Death		1 X Ir		28b. T	patient 3 DO	/A	4LI Nursaig n	ome 5 Resid	ienca 6 Oth		)
Affer fune	tlon	tX Natural 5	Pending investigation	(Monti	h, Day Year)		jury M	Bc. Inju Wo	rk? ]Yes 2□No	200. 50001601	ion injury cocur	00	
Division or Attending after deeth. Director: After tin by the fune	flca	0 = 0 0.0.00	Could not be		of Injury - At I	nome, far	m, street, factory					er or Rural	l Route Number,
Diversity of the direction of the direct	Certification:	4 Homicide	Getermined	buildin	ig, etc. (Spec	ify)	,			City or Tow	n, State)		
Division of Vita To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Cartifier 1	Certifying Ph	ysician: To the I	best of my kn	owledge,	deeth occurred	et the ti	me, date and place	, end due to the	cause(s) and ma	innar as st	ated.
n 24 n Fu	edical	(Check only 2 one)	Medical Exam	niner: On the ba and mann	sis of examin	ation and	Vor investigation,	in my o	opinion, deeth occu	rred et the time,	dete end plece,	and due to	the cause(s)
To the To the Comp	Σ	29b. Signature and title	of certifier	- 1 no	*		29c	Licens	se number		29d. Dete signe	d (Month, [	Day, Year)
10		M	2ctc/	Celle	m	(SU)	17	2	6765		MARCI	427	2000
V		30. Name and address	of person who	completed cause	of death (tte	m 23a) F	Type, Print)			-0			
		HECTOR		11,50Ni		. 8	401 Co	155	SoillE K	9. 310	5.1.5	09.11	ns 20910
Sta		31. Date filed (Month, I	R 3 0 20		nistrar's Sign	ature	1		,				
Registr	al	MIAI	100 20	00	The contract of	_	. 600	uls	/				



Piease Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death CZAKOWSKI Month Yee **Physician** RAYMOND 3 MARCH 25 2000 /Medical 4c. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Am **Examiner** Northwest Hospital Center Randallstown Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Hours Months Days 17 M 20 F 217-03-8005 83 Yrs. 13, **Director** August 1916 Maryland Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No MD Directo Baltimore Reisterstown 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 12600 Mount Laurel Court 21136 238 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Detes: WWI Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Bleck, White, etc. "natural", or Ita-idical Examinar 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Chief of Security Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Czakowski Wanda Pifarfki Philip 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if Item 27 is or other tre Mrs. Ida F. Czakowski (Wife) 12600 Mount Laurel Court Reisterstown, MD 21136 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) All County Cremation Serv. 3/26/2000 Sykesville, MD 22 Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) 21. Signeture of Funeral Service Licensee Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final PNEUMONIA diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dtnknown

þ The law requires Be Completed or Attending Physician: Certification: To After 24 hours after death.

Funeral Director: A filled in by

21215-0020

Baltimore, Maryland

Box 68760.

P.O.

Records,

of Vital

Division

Hospital

within 2 the th

OBSTRUCTIVE DULMGNAMY BISEASE 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Syvonomo WITH 1 Yes 2 No 1 Yes 20 No SEIZURE BISENDEN 25. Wes case referred to medical exeminer?
1 Yes 2 10 26. Place of Death (Check only one) Hospitel: 1 phopatient 2 FP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neture 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner steted. 29e. Certifier (Check only one) 29b. Signeture end title of confilien 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

edicai

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) GRIANDO CONANTAN

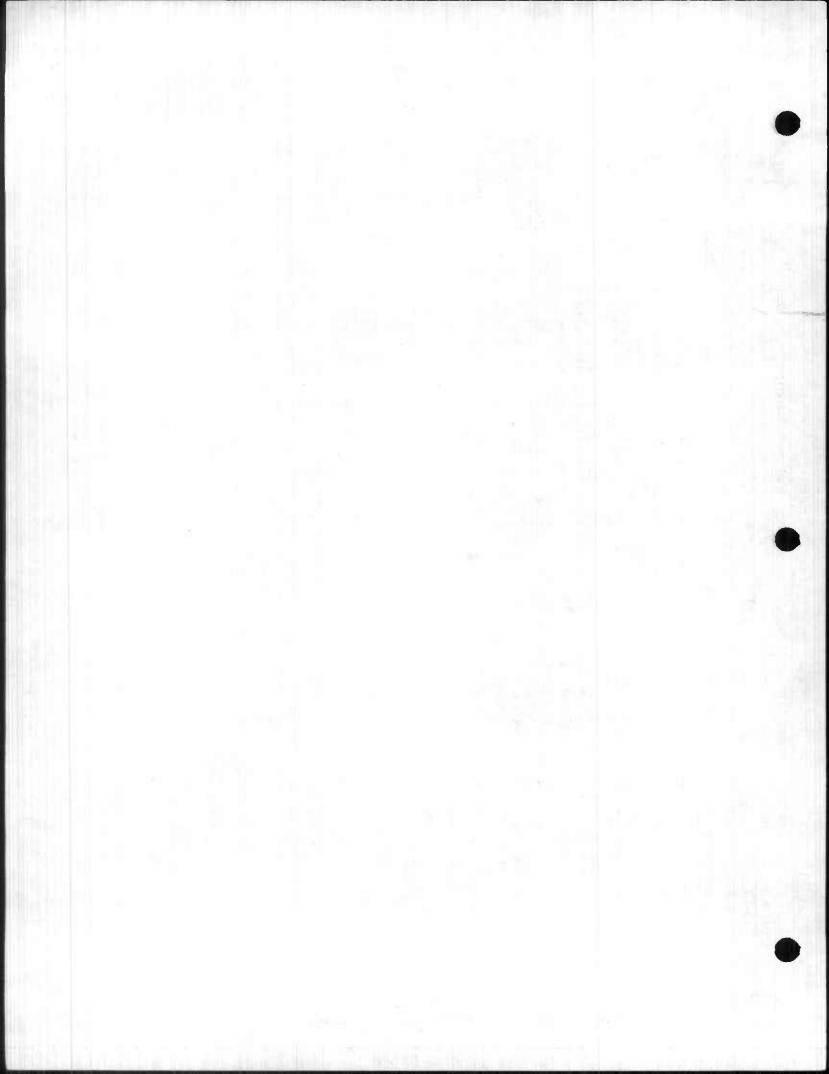
D18502 MARCH 25. 2000 RANDANSTONN, Manyland 21133

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

MAR 2 8 2000

books



State of Maryland / Department of Health and Mental Hydiene 00

			Cert	tificate of	Death		Reg. No.	0 1	1101	
Physician /Medical	Decedent's Neme (First, Middle, L HELEN	B. DAVIS				2. Data of De Month MARCH	Day	Yaar 00	3. Tima of Death 1:20AM	
Examiner	4a Facility Nema (If not institution, g POTOMAC MAN	OR CARE			POTOMA		MONT	GOME	RY	
Funeral Director	5. Social Security Number 6. 577-30-5126		s. last birthday) () Yrs.	Months Days		8. Data of Bir (Month, Da AUG . ]	th 7,1909	9. Birthpla Country MICI	ca (State or Foreign	
Maryland if show fied at tor	10a. Steta 10b. County		City, Town or Loc	ation				100	d. Inside City Limits 1 X Yas 2 No	
ath with the Marylan 23a or 28a-f show ust be notified at ral Director	I TOLT FOLDING	TENNIS LAN	E	10f. Zip Code 2085	4		10g. Citizen of V		y?	
urs after des aft, or flams Examiner in by Fune	3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of A		Specify Yes or No rto Rican, atc.)	14. Rac Blac Specify	e - Amaricar ck, Whita, etc. WH	c.	
od within 72 ho ygiene. wer than "naturn it, the Medical. Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give k		pation during most of we d)	orking 16b. Kind of Businass.			stry	
ked other the fice event, the	17. Father's Name (First, Middle, Las	5+ () IRNS	T1	EACHER			First, Middle, Maiden Sumame) IE HOLLINGTON			
ath and Me 27 Is mark r traumatic	19a. Informant's Name/Ralationship ROBERT G.	(Type, Print) DAVIS (SON)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 7802 VILLA LAKE DR HOUSTON, TX.						
nent of Hear int: If Nem iny or othe	20a. Mathod of Disposition  1  Burial 2  Cremetion 3  4  Donation 5  Other (Spec	Removal from Stata	Place of Dispos	ition (Name of etory or other pla	ce)	Date /26/00	n, Stata			
Departs Imports any inja anse inja	21. Signature of Funaral Service Lice	ala				FUNERAL		200	11	
hysician /Medical Examiner	23a. Part 1. Enter the dispase, of conshock, or heart failure. List only immediate Causa (Final disease or condition resulting in death)	. Prieumo			ng, such äs cerdie	ac or respiratory a	rrest,	i li	Approximate ntarval Batween Onset end Deeth	
fileste be executed  physician and  se the burial-transit  edical Examiner	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events)	c	(or as a consequ		VE PUL	Truonded DISEUSE.				
0 0 0	rasulting in death) Last	d								
v requires that the death cert been signed by the attending should be detached for usa a leted by Physician/M	Part II. Other significant conditions - DENYDRA	contributing to death but not re	esulting in the unc	derlying cause gi	ven in Part I.		23b. Did tobacco use contributa to ti		he cause of death?	
2 % N Q	- RENAL I	NZALSICKENI	y				an autopsy med?	avaii	a autopsy findings able prior to pletion of cause path?	
certificate has rector, page 2 irector.	25. Was casa refarred to medical			26. Place of De	alth (Check only)	7	10'	Yas 25kNo		
를 들는 는	examiner?  1 Yas 22No  27. Manner of Death  1. Naturat 5 Pending 2 Accident Invastigation	examiner?  1				eath (Check only one)  Homa 5 ☐ Rasidence 6 ☐ Othar (Specify)  28d. Describe how injury occurred				
To the Hospital or Attanding Ph within 24 hours shard death. To the Furneral Director: After th completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not determined	DB Dlace of Injury At	1 Yes 2 No  281. Location (Street end Number or Rurel F City or Town, Stete)			Route Number,				
Ne Hospita n 24 hours ne Funeral pletely fille edical C		hysician: To the best of my lor miner: On the basis of axamir and manner stated.								
Within Some	29b. Signetura and titla of certifier	Lul	14-14.	29c. Licens	se number 14656		29d. Date signe	d (Month, Di		
	30. Name and addrass of person who	completed ceuse of death (Ite	am 23a) (Type, P	rint)						

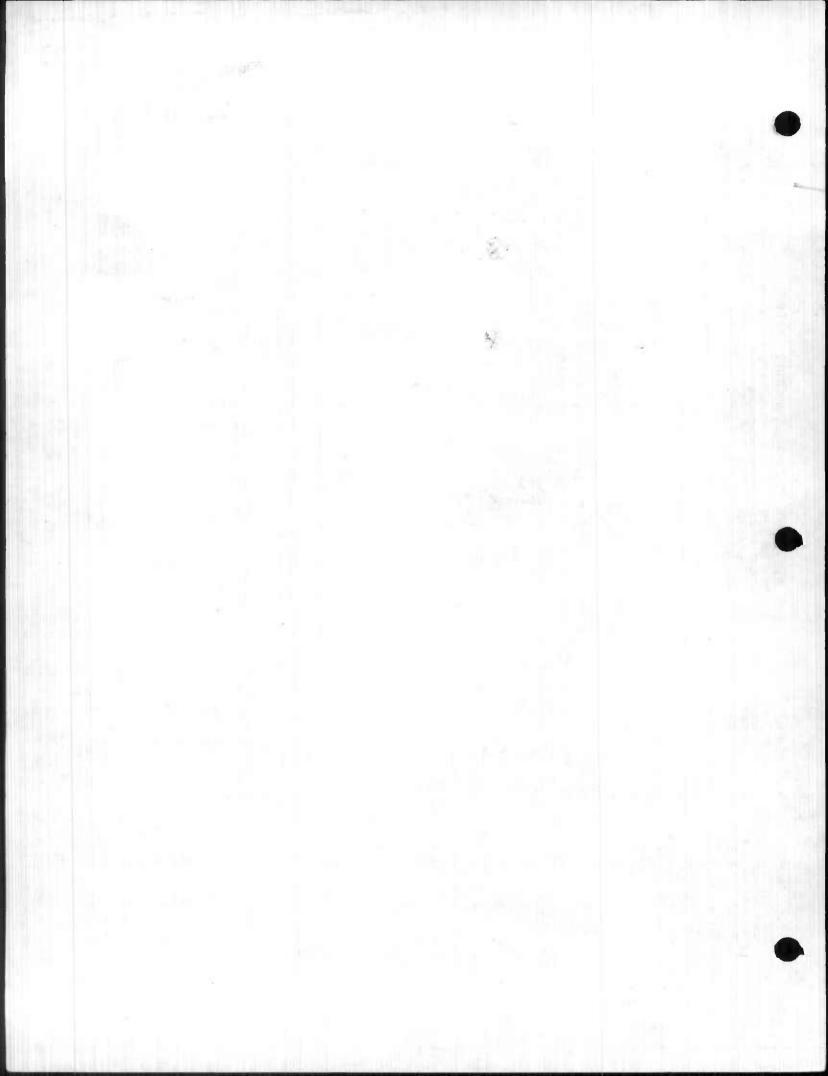
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31. Data filed (Month, Day, Year)

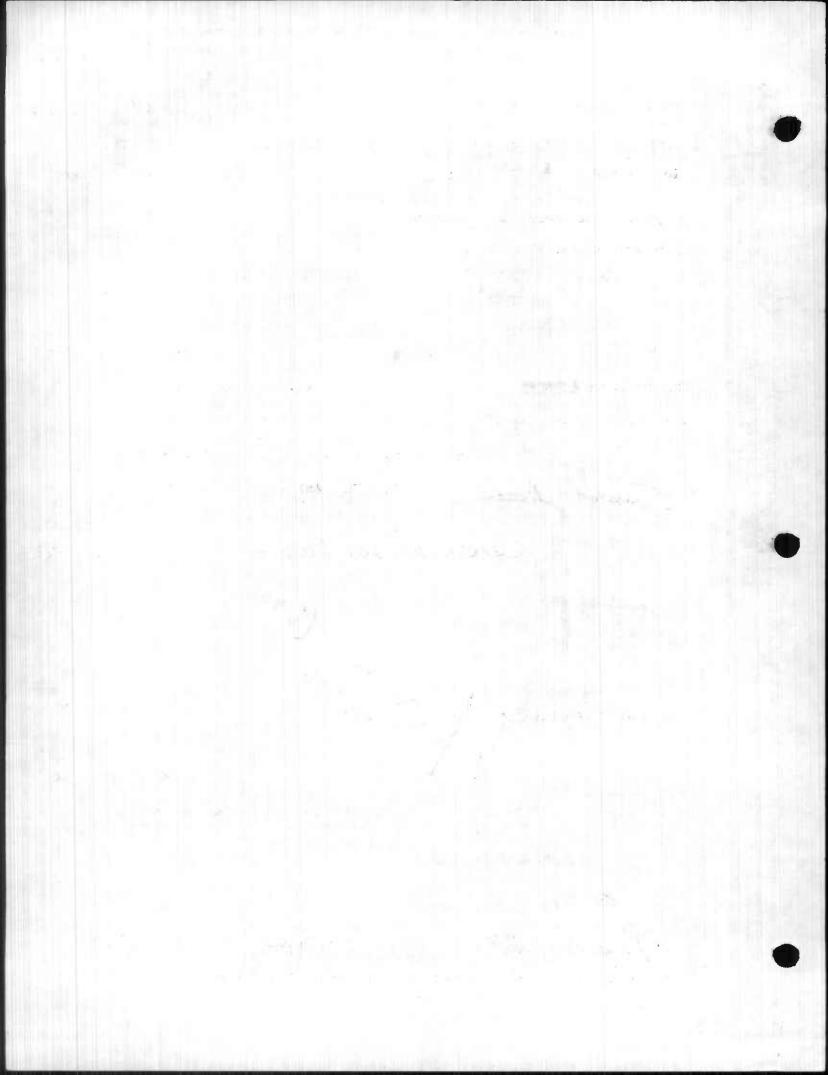
MAR 2 9 2000

TIP WOODWARD, M.D. 5530 WISCONSIN AVE. #550, CHEVY CHASE, MD. 20815



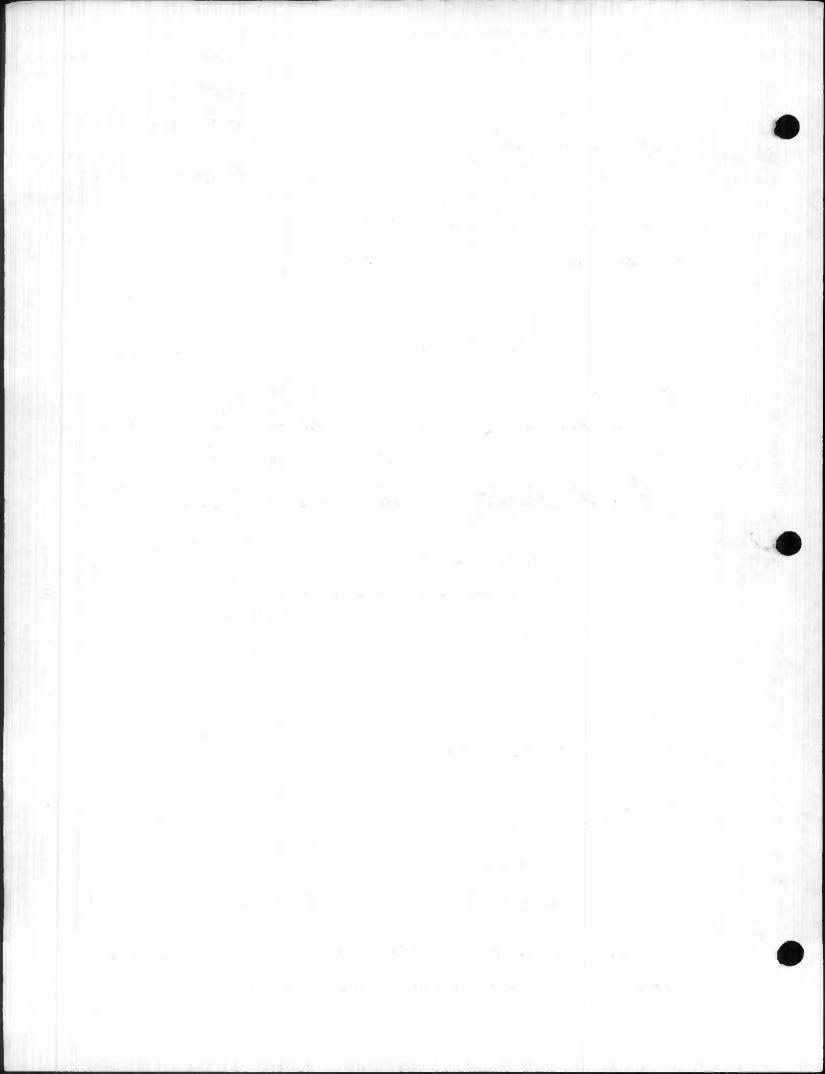
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			Certificate of	f Death		Reg. No.	
	1. Decedant's Name (First, Middla, Last)				2. Data of Dec		3. Time of Death
Physician	DeVota Harper DeM	larco			Month	24, 200	7:55 p.n
/Medical Examiner	4e Facility Nama (If not institution, give stre			4b. City, Town, or L			
.xammer	12656 Price Distill			70		Manha	
	5. Social Security Number 6. Sex	7. Age (In yrs. lest bi	rthday) If Undar 1 Yaa	Damascus It Undar 24 Hrs.	8. Data of Birti	Montg	
eral ctor		2⊠ F 91	Yrs. Months Dey		8. Data of Birth (Month, Day		9. Birthplaca (Stata or Forai Country)
101	Usual Rasidance of Decedent	71			January	27,1909	Kansas
10	10a. Stata 10b. County	10c. City, Tow	m or Location				10d. Inside City Limi
0	Maryland Montgomery	Damasc	us				1 ☐ Yes 2 ☒ N
2	10e. Street and Number		10f. Zip Coda			10g. Citizen of Wh	nat Country?
by Funeral Director	12656 Prices Distill	ary Road	20872			USA	
by Funeral Director	11. Meritel Status 12.	Was Decedent Ever in U,S.	13 Was Dacedent of	Hispanic Origin? (Sp	ecity Yas or No-	14. Race	- American Indien,
5		Armed Forcas? 1 ☐ Yas 2 🕅 No	If Yas, specify Cu	ban, Maxicen, Puerto	Rican, atc.)		, White, atc.
×	3 Widowed 4 □ Divorced	If Yas, Giva Yaar or Datas:	1 ☐ Yas 2]X) No	o Specify:		Specity:	White
P	15. Decedent's Educeti		. Decedant's Usual Occ	upation		16b. Kind of Bus	inass/industry
et	(Specify only highest grade co	mplatad)	(Giva kind of work don lifa. DO NOT usa ratii	e during most of work	ing	TOD: NING OF DOG	modern adding
To Be Comp	Elamentery/Secondary (0-12)	College (1-4or 5+)	cretary	00)		Federal	Government
ပိ	17. Fathar's Nama (First, Middla, Last)	36	cletary	18. Mother's Nem	a /First Middle		
To Be Completed							
P	Charles Lewis Harper			Emma I1			
	19a. intormant's Name/Ralationship (Type, Theressa D. Brown -		o. Malling Addrass (Street 1 Lastner I				itata, Zip Coda)
				alle Green	-		
	20e. Method of Disposition 1 ☐ Burial 2 🖺 Cramation 3 ☐ Rame	comete	ot Disposition (Nama of ery, crematory or other p	iaca)	Date		City or Town, Stata
	4 □ Donation 5 □ Other (Specify)	Chesap	eake Cremat	ory, Inc.	27,2000	Beltsvil	Lle, MD
	21. Signatura ot Funaral Service Licensee		22. Nama end Add				
1:	15 Caffel to		RAPP Fune	ral & Cr Avenue Si	emation	Services	20910
	23a Part Entar the disease or complicati	ons that caused the death. Do					Approximete
	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shocks are the shock of the	euse on each line.		, ,			Intarval Betwaan Onset end Deeth
า	Immediata Causa (Final	Carelano		1 milas			2 mode
	disaasa or condition rasulting in daath) a	Cerebron	asonav	HOGOWA			Zweek
-		Dua to (or as a	consequence ot):				
- ju	b. —			10Mg)			
xar	Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying	Dua to (or as a	consequence ot):	10/10			
E I	Ceusa (Disaesa or Injury			10			
Medical Examiner	that initiated avants rasulting in death) Lest	Due to (or as a	consequence of):	. 0			
Z e			1º	)	•		
an	<u> </u>		70	2			
0	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying cause	given in Part I.	23b. Did 1	obecco use cont	tribute to the causa of deat
Phy	HAD FEDERAL	Pal	1		10	Yes 2 No	3 Probably WUnkne
by	- In the contraction	7/1/	0,				
Completed by Physician		11			24a. Was	an autopsy rmad?	24b. Wara autopsy tinding available prior to
ple		// //					completion of cause of death?
E					101	res X No	1 ☐ Yas 2 No
BeC	25. Was cesa reterred to medical			26. Placa of Dea	h (Check only o	ma)	
ToB	axaminar? 1 ☐ Yas 25 No Hoss	oital:	utpatient 3 DOA	Mhan		dance 6 Other	r (Specify)
= =		8a. Deta of Injury 28b.	Tima of 28c. In			now Injury occurre	
to	1 Natural 5 Panding 2 Accident Investigation	(Month, Day Yaar)		/ork? □ Yas 2 □ No			
Ica	3 ☐ Suicide 6 ☐ Could not be	8a. Place of Injury - At homa, for	arm streat factory offic	A	28f. Location /5	Street end Numbe	r or Rural Routa Number,
T	4 Homicida datamined	building, atc. (Spacify)	ann, oneas, recory, one		City or Tov	vn, Stata)	
Medical Certification:	200 Codffee					4.	
S		<ul> <li>To the bast of my knowledge</li> <li>On the basis of examination are</li> </ul>					
Medical Certification		and mennar stated.	20s ties		-	and Data simual	(Marth Pau Vans)
-	29b. Sign and and title of certifler	10	29C. LIGH	nsa numbar		290. Data signed	(Month, Day, Year)
	Low my	JOHN )	D	1/499		0/20	
		eted cause of death (Item 23a)	(Type, Print)	-4 W1 0	0006 /5	1.2	
	Barry M. Rabin;	2012 Veirs Mi	LI Kd., Whe	aton, Md. 2	0900-43	1.3	
Casas	31. Data tiled (Month, Day, Year)	32. Registrar's Signature					
State		All I	9. Some				

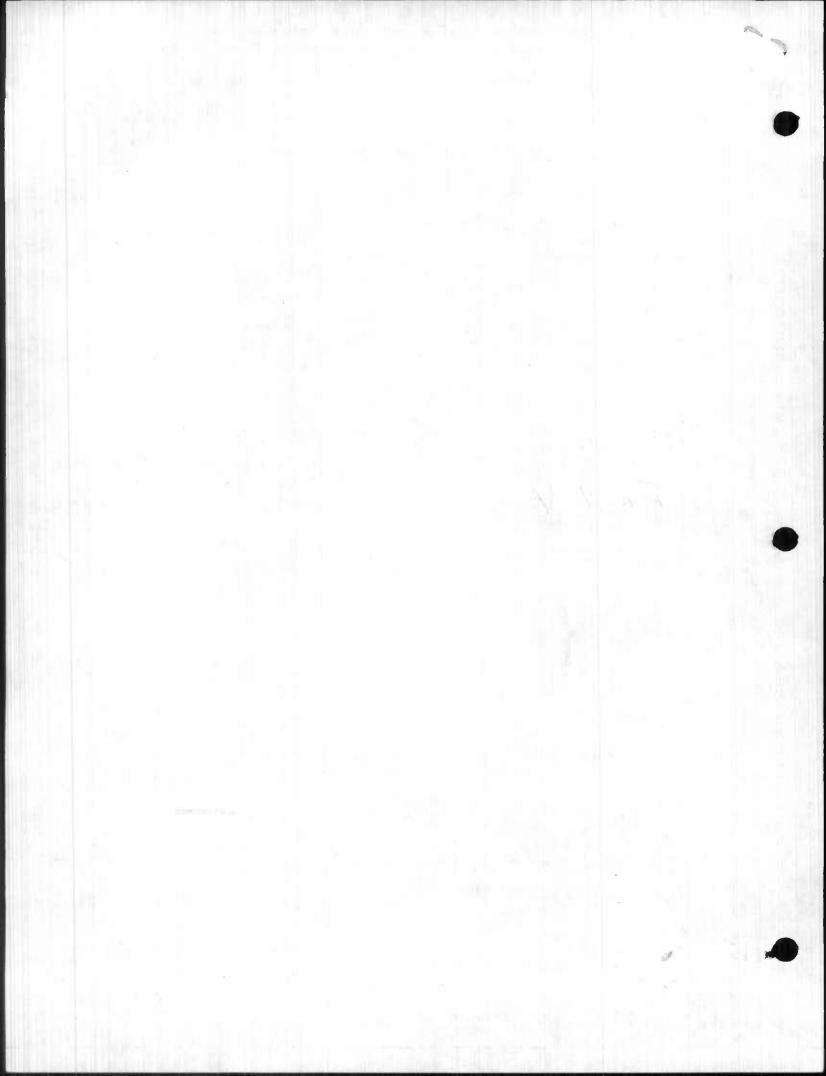


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

	ame	nd :	item 5, 29a per md G782 4/19/00			rtment of F tificate of	lealth and M <i>Death</i>		ene ()	0 1	1739
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Grace Collins Dunn					2. Date of Death Month March 2	Day	Year ()	3. Time of Death  3:58 am
	Exami Funeral Director		4a. Fecility Neme (If not Institution, give street and num  Montgomery Hospice— Case  5. Social Security Number (83-0)-4356  072-01-4578				4b. City, Town, or Lo  Rockville  If Under 24 Hrs.  Hours Min.		4c. County Montg	of Deeth omery	ace (State or Foreign
7	pu *		Usuel Residence of Decedent  10e. State 10b. County	10c. City, To	own or Loca	ation		1101 10,	1311		d. Inside City Limits
	the Maryler r 28e-f show	Director	Maryland Montgomery  10e. Street and Number	Silve	er Spi	ring 10f. Zip Code		10	g. Citizen of \	What Countr	1 ☐ Yes 2 No
50	swithin 72 hours after death with the Marylend liene. I then "natural", or items 23a or 28s-f show the Medical Examiner must be notified as	Funeral	t Never Married 2 Married 1 Yes	2 📉 No		20906 es Decedent of Heres, specify Cube	dispanic Origin? (Spe an, Mexicen, Puerto I Specify:		Blad	e - America ck, White, et	ic.
Maryland 21215-0020	within ane. than "	Completed by	3 ☑ Widowed 4 □ Divorced	tes: 18 4or 5+)	8a. Decede	int's Usual Occup ind of work done O NOT use retired		ng	Sb. Kind of Bi	usiness/Indu	
ryland 2	Mental Hyg Mental Hyg arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last)  John Collins				18. Mother's Name	(First, Middle, Me ins	elden Surnen	10)	
altimore, Mai	of Healt f Item 2		19a. Informent's Name/Relationship (Type, Print)  Charles C. Dunn/ Son  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removat from S	20b. Ptaca	13101 a of Disposit etery, crema	Laurel tion (Neme of atory or other plea	Glen Road  Ce)  Cemetery	Daje 3/28/	n, VA	20124 City or Tow	n, State
Baltir	permit. Peg Department Important: I any Injury o		4 □ Donetion 5 □ Other (Specify)  21. Signature of Funeral Service Licansee  Liu S. Sceric	20	Fra	Name end Addre		Funeral		Inc.	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)  A Meta:	used the death. D ch line.  Static Lu  Due to (or as	ing Ca	ancer	ng, such as cardiac o	r respiratory erres	it,	C	Approximate Intervel Between Onset end Death
x 68760,	certificate be executed ding physician and ise as the burial-transit	/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	Due to (or as	a conseque	enca of):	the lung			•	o months
.O. Box	that the death certified by the attending deteched for use as	Physician/M	Part II. Other significant conditions contributing to dea	th but not resulting	g in the und	leriying cause giv	ren In Part I.	23b. Did tob	acco use co	ntribute to t	he cause of death?
م	8 50	by	Hypertension								bly 4 Unknown
Recor	has b	Completed	Chronic Obstructive Pul	monary Di	isease	2		24e. Was an performe	ed?	evail comport de	
of Vital Records,	hysician: this certific al director,	To Be		patient 2 ER/0		3□ DOA Oth	4 Li italising Flori	ne 5 Residen	ca 8 X Oth	er (Specify)	Yes 2NNo Hospice
	tending leath. tor: After the fune	Certification:	2 Accident investigation 3 Suicide 8 Could not be determined 28e. Ptaca of	of Injury - At home, g, etc. (Specify)	o. Time of Injury		Yes 2 □ No	8f. Location (Stre City or Town,	et end Numb		Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edlcai C	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the base and manner	is of examinetion a	ge, death o and/or inves	occurred at the tin stigation, in my o	ne, date and placa, a pinlon, deeth occurre	nd due to the cau d at the time, date	se(s) and ma e and placa,	nner as stet and due to ti	ed. ne cause(s)
	To the vithin 2 complet	Me	29b. Signature end title of certifier	Pas	47	29c. Licens			d. Dete signer		
	1 -		30. Name end eddress of person who completed cause						arch 2	4, 200	)0
	Sta Registr		31. Dete fited (Month, Dey, Yeer) 32. Re	O Connectifications Connectification Con		Sporks	Kensington	n,MD 2089	95	_	



AMEND#10E C Amend #26	10E&F PER INFMNT 4-28-00 ,3/31/2000, BMW, Mont	G78Z JAB	Certificate of	Death	Reg. No.	11/40
Physician /Medical	Decedent's Name (First, Middle, Last,     Ermelindo R. Fajar     4a Facility Name (If not institution, give	do		2. Dete of E Month  March  4b. City, Town, or Location of Determined to the control of the contr	Day Year 28, 2000	3:19 am
Examiner	3016 Gold Mine Roa 5. Social Security Number 6. Se	7. Age (In yrs.	Months Davs	Hours Min. (Month, L	Montgome  Birth Day, Year)  9. Bir	Ty thplace (State or Foreign
Director Purplement Pu	579-16-1402  Usual Residence of Decedent  10a. State 10b. County	61	ty, Town or Location	Apr 2	6, 1918 Pu	erto Rico
with the part of 28s	FLORIDA LEE  Maryland Montgomes  10e. Street and Number  10940 BROWN PELICAN C	ry When	aton 10f. Zip Code	33928-0000	10g. Citizen of What Co	1 ☐ Yes 20 No
O2(O2)	3 X Widowed 4 □ Divorced	1U.€ 12. Was Decedenf Ever in U Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Year or Dates:	7,S. 13. Was Decedent of fit Yes, specify Cul	Hispanic Origin? (Specify Yes or Noen, Mexican, Puerto Rican, etc.)  Specify: Puerto Ric	Bleck, Whit	
15. n 72	15. Decedent's Edu (Specify only highest grade	cation e completed) Cottege (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of working	16b. Kind of Business.	/Industry
	17. Falher's Name (First, Middle, Last)	4	Mechanical En	gineer 18. Mother's Name (First, Midd	Engineer  de, Maiden Surneme)	
S should end Men end Men end Men end Men end merke	Ermelindo Fajardo 19a. Informant's Name/Reletionship (Ty	pe, Print)	19b. Mailing Address (Street	Isabella Colla et and Number or Rural Route Num		Zip Code)
Baltimore, Moemit Pages I and Journal of Health Important if I Imm 27 in y Injury or other trues.	Terry Lee/ Daughte  20a. Method of Disposition  1  Burial 2 Cremation 3 Pr	20b. F	Placa of Disposition (Name of cemetery, crematory or other pl	·	20c. Location - City or	Town, State
Baltin permit. P Departme Important any injury ands.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenary		Francis J	emetery 3/30/0 cost facility Funera rsity Blvd., W,	1 Home, INC	•
Physician /Medical Examiner	shock, or heert failure. List only of Immediate Cause (Finat disease or condition resulting in death)	ancen	or as a consequence of):	state	134	Interval Between Onset and Death
Box 68760, asth certificate be executed strending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest		or as a consequence of): or as a consequence of):			
P.O. hat the do by the detached	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying cause g		d tobacco use contribut	to the cause of death?
The law requires that The law requires that Tate has been signed to page 2 should be det Completed by P					rformed?	Were autopsy findings available prior to completion of cause of death?
= F # 8 0	25. Was case referred to medical			1 E 26. Place of Death (Check only		1 Yes 2 No
O the state of T.	1 Yes 2 No  27. Manner of Death 120 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	28b. Time of Injury W	ther: 4 Nursing Home variety at ork? 28d. Describ	e how injury occurred	inter's residence
Division Completed to the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	building, etc. (Specif		City or 1	(Street and Number or Rown, Stete)	
To the Hospital within 24 hours of To the Funeral I completely filled Medical Ce	29a. Certifier (Check only one)  29b. Signature and title of certifier	ilcien: To the best of my knoter: On the bests of examine and menner steted.	ition and/or investigation, in my	time, date and place, end due to the opinion, death occurred at the times number	e cause(s) and manner a e, date and plece, and du 29d. Date signed (Mon	e to the cause(s)
15	1 Hey m	Curp.	mo DI	2256	3/30/5	روين
	30. Name and address of person who co	mpleted cause of death (Iter SE, Registrar's Signa		DICAL PARK &	DR SILVER	SPRING
State Registrar	MAR 3 1 200	8 serve	B. Spore	2		



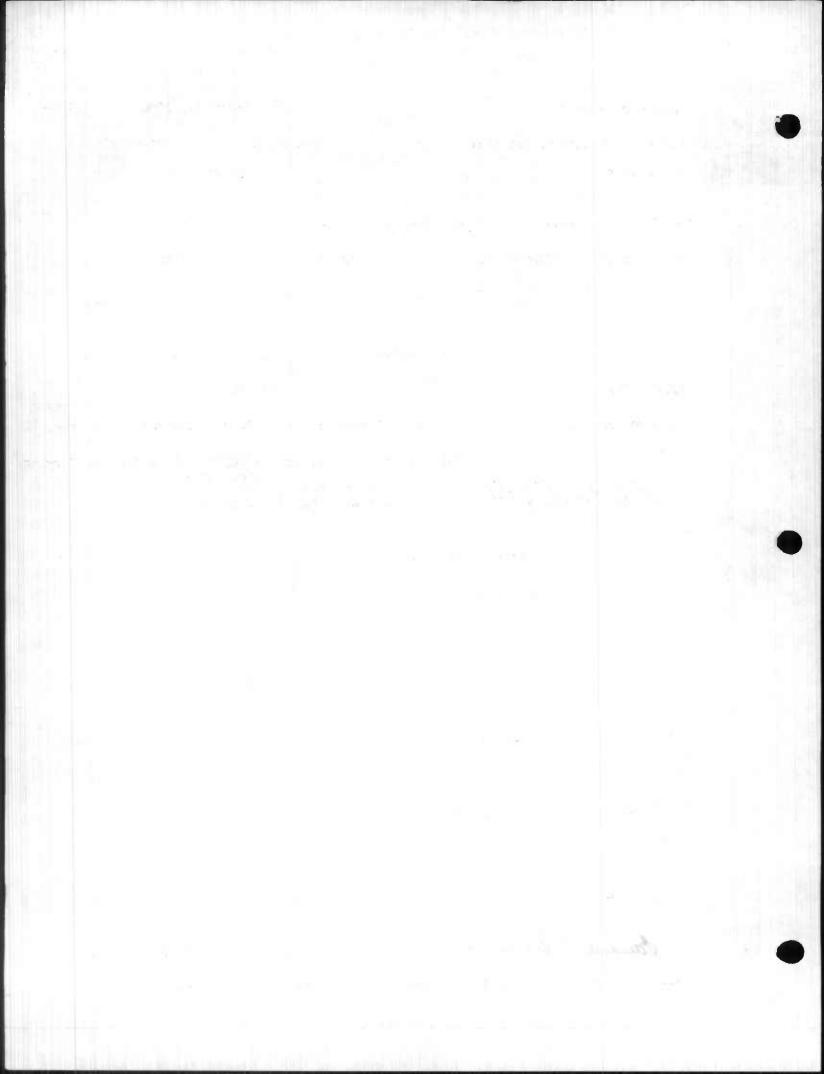
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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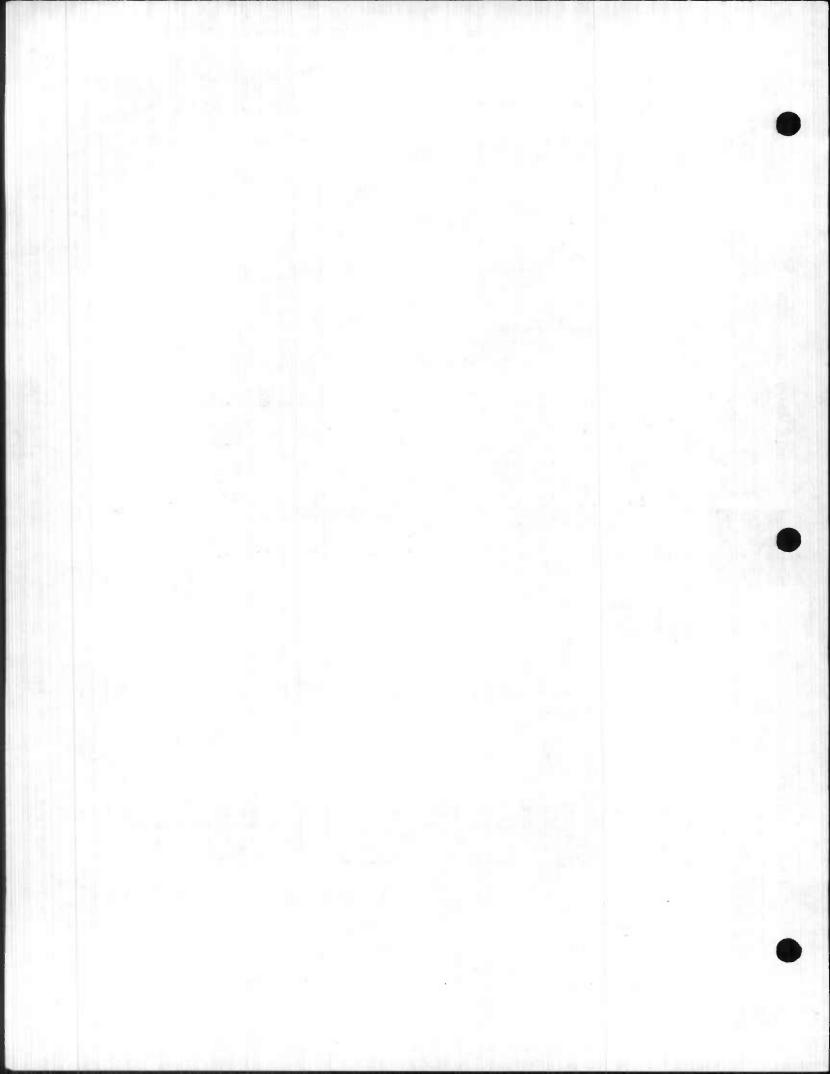
						Jerui	icale of	Dealli		Re	g. No.		
Physic /Medi		1. Decedent's Name (First, Midd Joseph Ferrare	lli						2. Date Mon Marc	of Deeth th h 24	Day	Year	3. Time of Death 8:54pm
Exami	ner	4a. Facility Name (If not institution Frederick Memory						4b. City, Town	n, or Location of	Death	4c. County	y of Death lerick	
Funeral Director	Ī	5. Social Sacurity Number 217–42–4463	6. Sex	7. Aga (In	yrs. last birth		Under 1 Year onths Days	If Undar 24	Hrs. 8. Data Min. (Mon	of Birth th, Dey,			laca (State or Foreig
D ,		Usual Residence of Decedant											
within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28e-1 show a Maryland and	Director	Maryland Montg  10a. State 10b. County  Maryland Montg			ontgom	ery	Villag	e		10	g. Citizen of		0d. Inside City Limit 1 ☐ Yes 255 N
23a or	Ö	8632 Fountain	7211ev	Drivo			2088	0.6			nited		,
ours ener dead al', or items 2 Examines mu	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	12. Wa Arr ried 1 [	as Decedant Ever med Forces? Yes 2 X No es, Give ar or Dates:	In U,S.			Hispanic Originan, Mexican, I	n? (Specify Yes Puerto Rican, et		14. Rad	ce - Amarica ck, White, e	an indian, etc.
"natural",	Completed		it's Education	alotod)	16a. C	Decedent'	's Usual Occup	pation	A complete o	1	6b. Kind of B		
Pan .	nple	(Specify only higher Elementery/Secondary (0-12)	1	llege (1-4or 5+)				during most o	r working				
Hygier Afher th	S	12	(		Ва	arbei	c				Hair		ng
Wental Mental Irked o	To Be	17. Fathar's Nama (First, Middla, UNKNOWN	Last)					U	NAME (First, MANN)				
is me		19a. Informant's Name/Relations	ship (Type, Pri	int)					or Rurel Route				40001
of Health of Health litem 27 i		Norma Ferrarel		2	0b. Place of D	532 I	Fountai in (Neme of ary or other pla	n Vall	ey Driv	e, M	ontgom Oc. Location -	nery V City or Tox	illage, N
tment tant: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funerel Service	pecify)	ii from State	-	Hea	aven Ce	metery	3/28/ DeVol	00 S	ilver	Sprin	g, Maryla
Depar impor any ir		21. Signature of Funeral Service	2/Consea	VAP		10	East D	eer Pa	Devoi rk Driv aryland	e		me	
hysician /Medical Examiner	er	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition rasulting in death)		rdiac Ar		nia_		ng, auch es ca	rulac or respira	lory arres	51,		Approximete Interval Between Onsat and Death Seconds
nding physician and use es the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last	6. <u>Hy</u>		On to (or as a co								
	sicla	Part II. Other significant condition	ons contributin	ng to death but no	t resulting in t	he under	tvina cause air	ven in Part i.	23b	. Dld tob	acco uae co	ntribute to	the cause of death
signed by the ett	by Phys						.,g				-		ebly 4 ☐ Unknow
aw requ	Completed b								24a	. Was en perform	eutopsy ed?	eva	re autopsy findings ilable prior to apletion of cause leath?
ate h	50									1 🗆 Yes	2 No	1 🗆	Yes 2 No
certificate	Be	25. Was case referred to medica examiner?					100		Death (Check	only one	)		
this aidi	2	1 ☐ Yas 25% No 27. Manner of Death	Hospital	1 LI Inpatient	2 ER/Outp		DOA		ing Home 5				)
After fune	Certification:	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation	. Date of Injury (Month, Dey Yea	28b. Tin Ir) Inju	ury	28c. Inju Wo 1 □	rk?  Yes 2 □ No		спре поу	w Injury occur	rea	
一一一	Certifi	4 Homicide determ	ined 28e.	Place of Injury - building, etc. (Sp		n, street,	tactory, office			tion (Stre or Town,		per or Aural	Route Number,
within 24 hours of To the Funeral Completely filled	edicai	29a. Certifier 1X Certifyin (Check only 2 Medical one)	Examiner: On	To the best of my the basis of exar d manner stated.	knowledge, on inlinetion end/o	death occ or Investi	curred at the ti gation, in my o	me, date and popinion, deeth	place, and due to occurred at the	o the cau time, det	use(s) and ma te end plece,	anner as sta end due to	ited. the cause(s)
Within 2	M	29b. Signature and title of certifle		lan ac	)		29c. Licens		7		d. Date signe		
· -		30. Name and address of person			(Item 23e) (Ty	ype, Print		0020007		_ PIč	aren Z	201 و ١	JU
Sta	ite	-	en, MD	d cause of death	sconsi		1)				28 0815	8, 200	)0



State of Maryland / Department of Health and Mental Hygiene

11742 Certificate of Death

Decedent's Name (First, Middle, La  LOUISE MAY  4a Facility Name (If not institution, given the second of the	FIELDS				2. Date of Dea Month	Dey	3. Time of Death	
and the second second second second	re street and number)			4h Ciba Tourn calls	MARCH			M
1 10012 AMELUNG LAI				4b. City, Town, or Lo				
5. Social Security Number 6. 5		. last birthday)	If Under 1 Yeer	ROCKVILI			TGOMERY	
	10 M 20 F 94	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day April 1	Year) 0, 1905	9. Birthplace (State or Foreig Country) N. Carolina	n
103-01-7027	Λ 94			4	Abrit 1	0, 1905	N. Carolina	
10a. Stete 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limit	s
NI Atlant	ic V	ontnor					1 ☐ Yes 2 ☐ N	Ю
		enthor	10f. Zip Code			10n Citizen of W	/hat Country?	_
Kege								
		IS 13 W			acity Ves or No.			-
	Armed Forces?	If	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Bleck		
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specify.		Specify:	white	
15. Decedent's E	ducation	16a. Deced	ent's Usual Occup	pation		16b. Kind of Bu		
(Specify only highest gra	ade completed)	(Give I	and of work done	during most of work.	ing			
Elementary/Secondary (0-12)	5+	Teac	her		1.5	Educas	tion	
17. Fether's Name (First, Middle, Last,	)			18. Mother's Name	e (First, Middle,	Maiden Sumam	9)	
Emery Eugene	May			Dove	А	bernath	V	
7		19b. Meiline	Address (Street					
20a. Method of Disposition	20b.	Place of Dispos	ition (Name of		Dete	,		
1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removel from State	cemetery, crem	atory or other pla	1 1	ar 31,			
		-						
21. Signapore of Fuperal Service Ligar	navy							
Day M.	Leci						, MD 20877	
23a. Peri Enter the disease, or come shock, or heary failure. List only	plications that caused the dea one cause on each line.	ith. Do not ente	r the mode of dyir	ng, such es cardiac	or respiratory er	rest,	Approximete Intervel Between	
0							Onset end Deeth	
tmmediate Cause (Finel disease or condition	ARTERIOSCL	EROTIC	CARDIOVA	SCULAR DI	SEASE			
resulting in death)	Due to (	or as a consequ	uence of):			4		
Sequentially list conditions,	Due to (	ience of):						
if any, leading to immediate cause. Enter Underlying								
that initiated events	C. Due to (	or es e consequ	ence of):				1	
1630 king in Godin) Last								
	d							
Pert II. Other significant conditions of	contributing to death but not re	sulting in the un	derlying cause giv	ven in Pert I.	23b. Did t	obacco use con	tribute to the cause of deati	h?
		Jamg in the underlying cause given in Pert I.						
SENILE DEMENT	LA .							
					репо	med?	completion of cause	
OF 181	r					21	1 Li Yes 2 Li No	
examiner?	Hospital:		C Off				a govia va	200
	1 L Inpatient 2 L		3LI DOA	4 LI Nursing no				ME
1 Netural 5 Pending	(Month, Day Year)	28b. Time of Injury			zou. Describé f	iow injury occurr	<del>o</del> u	
ZUNCKOSIII					006 Lecetion #	Daniel and Mr	nana Punal Pauta Marah	
	208, Place of Injury - At I				er of Hurai Houte Number,			
(Check int) 2 X Medical Exam								
one)	and manner stated.							
more proposition white the con-	4- 0		29c. Licens	se number		29d. Date signed	(Month, Dey, Year)	
29b. Signature and the of certifier								
290. Signature and the of certifier	M. B.		DI	5736		MARCH 30	2000	
30. Name and address of person who	completed cause of death (Ite	m 23a) (Tvpe, F		5736		MARCH 30	0, 2000	
30. Name and address of person who			Print)					
, 96		ROCKVIL	Print)	#211 RO	CKVILLE		0, 2000	
	Usual Residence of Decedent  10a. State	Usuel Residence of Decedent  10e. Stete 10b. County 10c. Co.  NJ Atlantic V.  10e. Street and Number Regency Towers  5200 Boardwalk, Unit 16E  11. Merital Status 12. Wes Decedent Ever in the Armed Forces? 1   Yes, Give year or Dates: 1   Yes, Give year year or Dates: 1   Yes, Give year year year year year year year yea	Usuel Residence of Decedent  10e. Stete 10b. County 10c. City, Town or Loc NJ Atlantic Ventnor  10e. Street and Number Regency Towers 5200 Boardwalk, Unit 16E  11. Merital Status 12 Wespecial Ever in U.S. Armed Forces? 1 Never Merried 2 Married 3 Widowed 4 Divorced Specify only highest grade completed) 11. Wespecify only highest grade completed) 12. Separative Secondary (0-12) College (1-4or 5+) Teac  17. Fether's Name (First, Middle, Last) 18. Decedent's Education (Specify only highest grade completed) 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mellin, Richard J. Fields, Son 15812  20a. Method of Disposition 1 Burial 2 Macrenion 3 Removel from State 4 Donester Schoter (Specify Specify) 5 Cother (Specify) Specify	Usual Residence of Decedent   10s. Stete   10b. County   10c. City, Town or Location   NJ   Atlantic   Ventnor   10s. Stete   10b. County   NJ   Atlantic   Ventnor   10s. Stete   10b. County   NJ   Atlantic   Ventnor   10s. Stete   10s.	Desire   10k County   10k Celly, Town or Location   10k Stefe   10k County   At antic   Ventnor   10k Stefe   10k County   At antic   Ventnor   10k Stefe   10k Celly, Town or Location   Ventnor   10k Stefe   10k Celly   10k Celly   10k Celly, Town or Location   Ventnor   10k Stefe   10k Celly   10k Cell	Toe. Size   10th County   Toe. City, Town or Location	Usual Residence of Decodered   N.J.	Usual Packbarce of Decaders   Usual Country   NJ   Atlantic   Ventnor   Usual Country   NJ   Atlantic   Ventnor   Usual Country   Ventnor   Usual Country   NJ   Atlantic   Ventnor   Usual Country   Unit of States   Unit 16E   S8406   Unit 16E   Unit of States   Unit 16E   S8406   Unit 16E   Unit of States   Unit of States   Unit 16E   Unit of States   Unit of States   Unit 16E   Unit



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 8:57 pm

March 24, 2000

	Physician /Medical	1. Decedent's Neme ( Louis Nea										2. Date of Month March	Dey	Year 000	3. Tima of Death 8:57 pm
	Examiner	4a Facility Name (if n			imber)					4b. City, To Beth		ocation of De		unty of Death	
	Funeral Director	5. Social Security Nun 123-16-883	6. 4	Sex 1 DAM 2 □ F	7. Age (In	yrs. last l	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of (Month, Sep 2		9. Birtt	nplace (State or Foreign untry) necticut
	H show	Usual Residence of D  10a. State 1  Maryland M	0b. County	rv		c. City, To									10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	23a or 28a-f s ust be notified ral Director	10e. Street and Numb	er					10f. Zip Code 20895					10g. Citizer		
		11. Merital Status  1 Never Merried  3 Widowed 4		12. Was Dec Armed Fo 1 DXYes if Yes, Gi Year or D	orces? 2 □ No ve W	win U,S.		Vas Deced i Yes, spec		dispanto Or an, Mexica Specify:		pecify Yes or Rican, etc.)		Rece - Amer Black, White pecify: Wh:	, etc.
15-0	eted and	1! (Specify	5. Decedent's E only highest gi	Education rade completed)		16	a. Deced	lent's Usue kind of wo	l Occup	ation during mos	t of worl	working 16b. Kind of Busine			ndustry
21215-0020	ygiena. Northan "naturi II, the Medical	Elementery/Second	ary (0-12)	College (	C	life. DO NOT use retired)  Civil Engineer					Private			dustry	
Maryland	Pagas 1 and 2 should be fill sent of Health and Mental H nt: if item 27 is marked out iny or other traumatic even To Be	17. Father's Name (Fit Tom FitzSi		18. Mother's Neme (First, Middle, Meiden Sumame)  Alma Canavello							mame)				
more, M		19a. Informant's Nam  Rebecca E  20a. Method of Dispos  1 □ Burial 2 □ X  4 □ Donation 5	Stafe	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Z.  fe 10149 Cedar Lane, Kensington, MD 20895  20b. Place of Disposition (Neme of cemetery, crematory or other place)  Metropolitan Crematory 3/28/00 Alexandria							Town, State				
Balti	Departiments any injury and injury in	21. Signature of Fune	ral Service Lice								al Home Silver		g, MD20901		
4	hysician /Medical xaminer	23a. Part 1. Enter the shock, or heart for Immediate Cause (Fir disease or condition resulting in death)		a Card	iac A	Arres	t s conseq	er the mod							Approximete Intervel Between Onset end Deeth

Certification: To Be Completed by Physician/Medical Examin ate hes been signed by the ettending physician and page 2 should be datached for usa as the bunal-tra After this certificate hes

NEAL 3-3-0

, tzsimows,

or Attending

death.

To the Hospital or Attended within 24 hours after deal To the Funeral Director:

filled in by

20

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

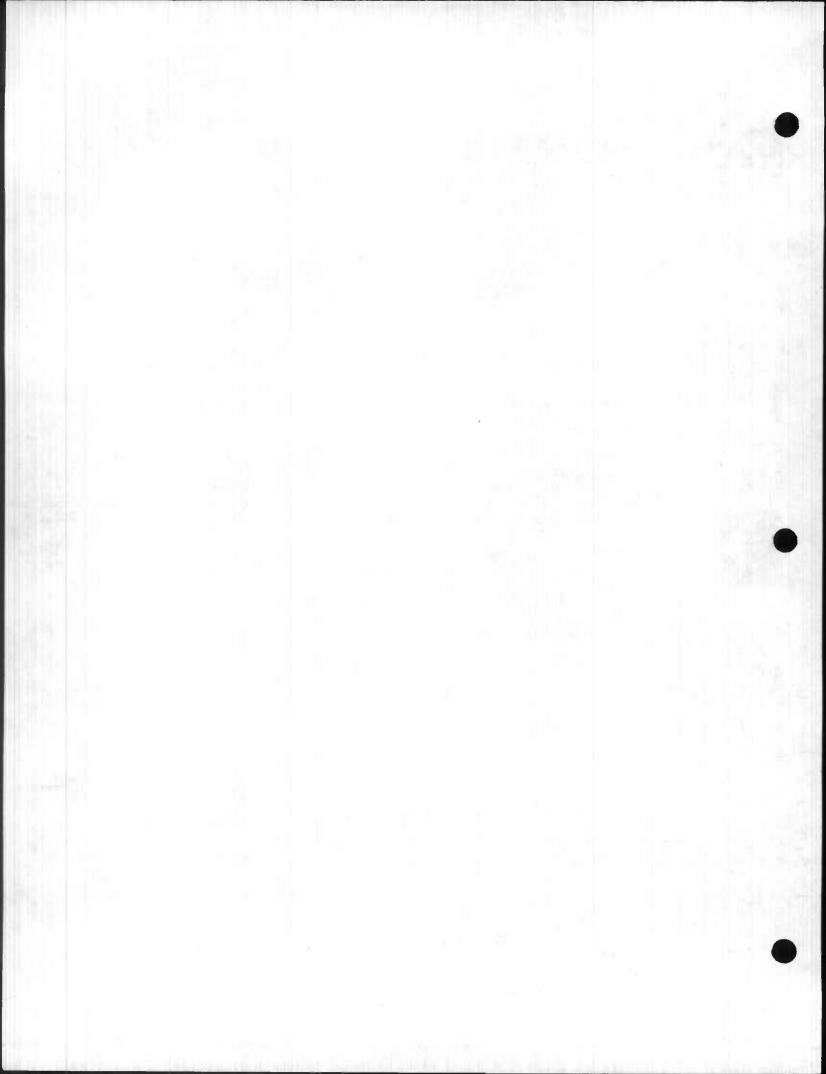
State

Kane, MD 31. Daye filed (Month, Day, Year) Registrar

Massachusetts Ave., NW, Washington, DC 20015 32. Registrar's Signature

30. Name and address of person who completed cause of death-(frem 23a) (Type, Print)

D 08694



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1764 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death MARCH 28 2000 08:40am FRIEDMAN DOROTHY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BETHESDA MONTGOMERY SUBURBAN HOSPITAL 09 2-54 - 9898 1 M 218 F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) JANUARY 22,1912 NEW YORK Months Days Hours 88 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 □ No MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 USA 10250 WEST LAKE DRIVE 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 Tho Myes, Give 1 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) LILLIAN KUSHNER KENNETH KABINOFF 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) BARBARA LEIGHT/ DAUGHTER 11217 BROAD GREEN DRIVE, POTOMAC, MARYLAND 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MARCH 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) 130. 2000 OLNEY, MARYLAND JUDEAN MEMORIAL GARDENS 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert Eber the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death acute myocardial infarction Immediate Cause (Final 6 day disease or condition resulting in death) Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings eveileble prior to 24e. Wes an eutopsy performed? completion of cause of daeth? 2 No 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

physician the burial signed by the attending to be detached for use DUNDING OF DE Records, Vital to this 23/28/2000 Division or Attanding 24 hours after death. To the Hospital within 24 hours To the Funeral

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

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Pages 1 and 2 should be nent of Health and Mental

of Health of Health or Other to

**Physician** 

/Medical

Examiner

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21215-0020

Baltimore, Maryland

Physician/Medical p Completed Be Medical Certification: To 27: Manner of Death 1 Neturel 2 Accident 3 ☐ Suicide

25. Was case referred to medical examiner? 1 Yes 2 No

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

29b. Signature and title of certifie wer MD

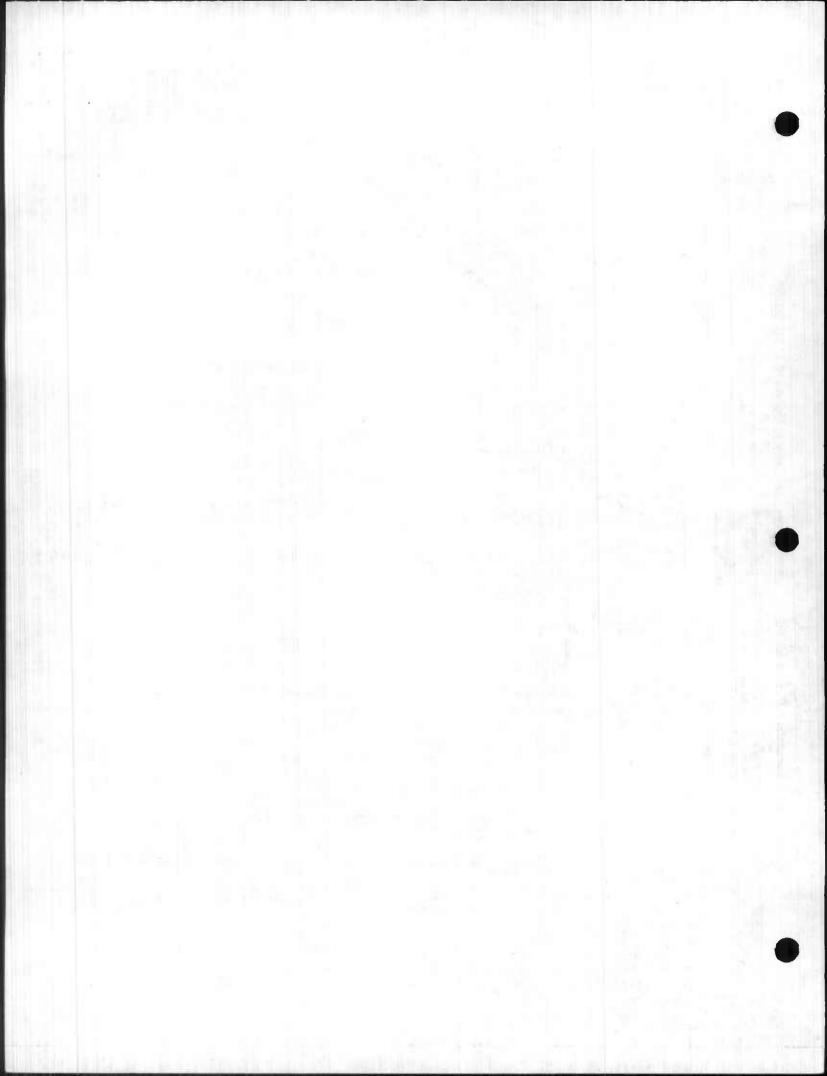
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCH 28,2000

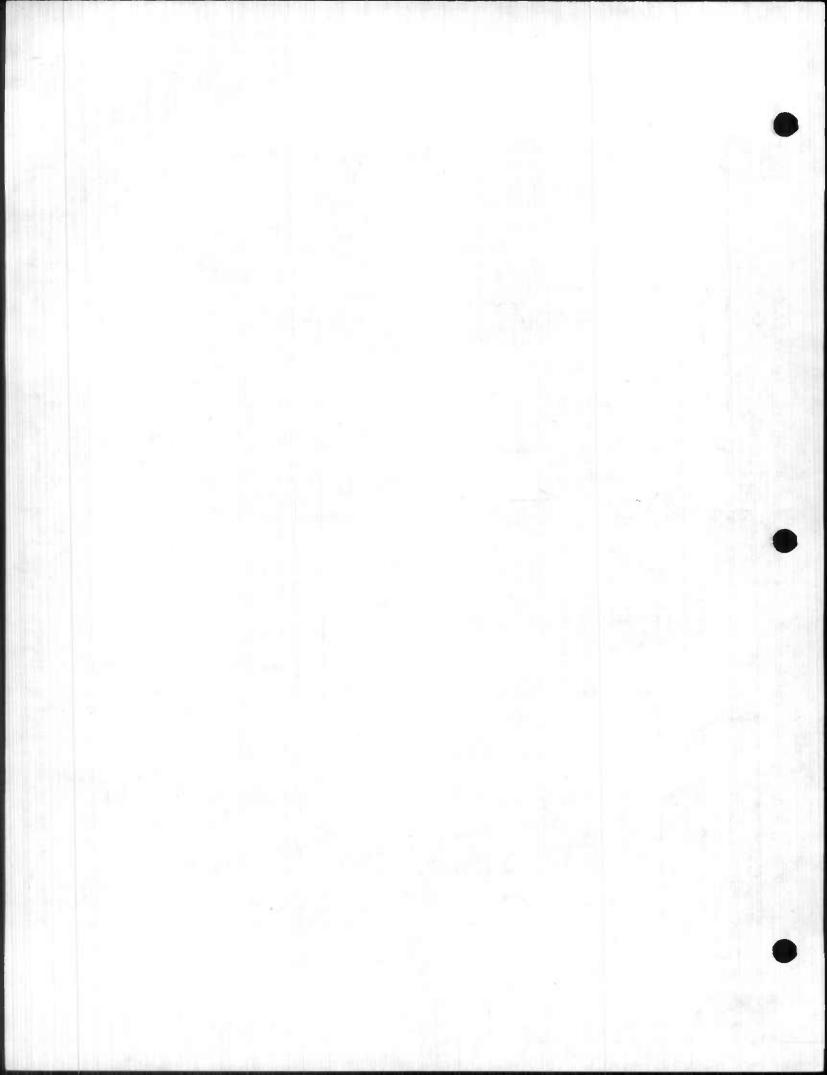
State Registrar 31. Date filed (Month, Day, Year) 2000 MAR 30

MD 32. Flegistrar's Signature

6410 ROCKLEDGE DR STEDO



				State of M	aryland		irtment of I <i>tificate of</i>		d Mental Hy	rgiene ()	0 1	1745
	hysician	1. Decedent's Nam	A STATE OF THE REAL PROPERTY.	sı) Mary Eilee	en Fun	k			2. Date of Do Month March	Desir		3. Time of Death 4:30 PM
100	/Medical Examiner	4a Facility Name (I	If not institution, giv	re street and number)				4b. City, Town,	or Location of Deal			
	uneral rector	Millenniu 5. Social Security N 220-26-43	1 6. 5 346		ge (In <i>yrs. las</i> 76	t birthday) Yrs.	If Under 1 Year Months Days			av. Year)	9. Birthplac	e (State or Foreign Land
fand	M 11	Usual Residence of 10s. State	Decedent 10b. County		10c. City,	Town or Lo	cation				10d	I. Inside City Limits
Mary	to de	Maryland	Montgom	ery		Olney						1 ☐ Yes 2 ☒ No
6	or 28a-1 be notified Directo	10e. Street and Nu	mber			THE I	10f. Zip Code			10g. Citizen of V	Mhat Country	n
6	rai da	3314 Bue	hler Cou	rt			208	32		Englar	nd	
5-0020 72 hours after death with the Maryland	al, or hams 23s or 28s-f show Examiner must be notified at by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 14 Yes, Give Yeer or Detes:		1	Ves Decedeni of Yes, specify Cut ☐ Yes 2 No	an, Mexican, Pu	(Specify Yes or Neerto Rican, etc.)		e - American ck, White, etc Whi	
Maryland 21215-0020 d 2 should be filled within 72 hours at th and Mental Hygiene.	t, the Medical Completed	(Special Special Speci	15. Decedent's Edity only highest grandery (0-12)		5+1		lent's Usual Occu kind of work done DO NOT use retire		working	16b. Kind of Be		
and 2 d be filed and a hygie	Be ever	17. Father's Name	(First, Middle, Last,	)			1100001	18. Mother's I	Name (First, Middle Available	, Maiden Suman		
aryla should and Men	To	19a. Informant's Na	ame/Relationship (	Type, Print)		19b. Meilin	g Address (Stree	t and Number or	Rural Route Numb	oer, City or Town,	State, Zip Co	ode)
	127	William K	. Funk/H	usband		3314	Buehler	Court,	Olney, Ma	ryland 2	20832	
5 TH	ury or oth			Removel from State	cen	etery, cren	sition (Name of natory or other pla eaven Cer		March 28,	20c. Location - Silver S		Maryland
Ball permit Depart	any inj	21. Signature of Fu	f Jan	1566	M0019	Rose 30 Rose	Name and Addr Della Mest M Ckville,	rumphire; ontgome: Maryla	y Funeral ry Avenue nd 20850	Home/Ro	ockvil.	le, Inc.
	sician	23a. Part1. Enter	ne disease, or com it failure. List only	plications thet cause one cause on each li	d the death. ne.	Do not ente	er the mode of dy	ing, such as card	fiec or respiratory of	errest,	A	pproximate iterval Between inset and Death
200	edical miner	Immediate Cause ( disease or condition resulting in death)	(Finel n	Met	astat	ic Ce	rvix Can	cer			1	year
	i i				Due to (or a	s a conseq	uence of):				1	
68760, floate be associted	physician and street transit to buriel-transit adjusted Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i	injury	b	Due to (or a							
. Box 6	d by the attending p etached for use as Physician/Me		L	d								7-50
D .	od for	Part II. Other signif	icant conditions o	ontributing to death b	ut not resulti	ng in the ur	nderlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to ti	he cause of death?
S, P.O	igned by the about the detached if by Physic								_ 1□	Yes 2 No	3 Probal	bly 4⊠ Unknown
ecord aw requir	2 should									s an autopsy omed?	availe	a autopsy findings able prior to oletion of cause ath?
- F	Com Com								10	Yes 2⊠No	101	res 2 No
Vital	Ctor	25. Was case reference examiner?	red to medical	Hospital:			0		Death (Check only	one)		
O A		1 ☐ Yes 2 ☑ 27. Manner of Deat		1 ☐ Inpatio		VOutpatien 8b. Time of	1 3LI DON		g Home 5 Res	how injury occur		
VISION Attending r death.	by the funeral	1 ØNatural 2 Accident	5 Pending investigation	(Month, Da		Injury	M 1	rk? Yes 2 No	200. 2000100	now anjury occur		
5 ba	in the	3 Suicide 4 Homicide	6 Could not be determined	28e. Piece of in	ury - At home c. (Specify)	e, farm, stre	eet, fectory, office			(Street and Numb own, State)	ber or Rural F	loute Number,
To the Hospital within 24 hours	To the Funeral Dir completely filled in Medical Ceri	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of end menner st	f examinetion	dge, death and/or inv	occurred at the trestigation, in my	ime, date and pli opinion, death o	ace, and due to the courred et the time.	cause(s) and me , date and place,	anner as state and due to th	ed. ne cause(s)
To the	M Som	29b. Signature and	title of certifier	0.0	/	20-	29c. Licen	se number	11.14	29d. Date signe	d (Month, Da	ly, Year)
	12	1	meu	delle	uel	UP n	10 D3	8262		March	24, 2	000
		A. Mendhi	ratta, M	completed cause of d			-	ite 340	, Rockvil	le, Mary	yland :	20850
R	State Registrar	31. Date filed (Mont		100	er's Signetur	· 1.	Spark	2				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day **Physician** March 28, 2000 Mary J. Giles 1:20 pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Sacred Heart Home, Inc. Hyattsville If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1 M 2 X F Yrs. 96 Nov 29, Director 577-60-0617 1903 Massachusetts Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director 28a-f N/A Washington 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? iber mat be n 2711 Terrace Road, 20020 USA SE Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 14. Raca - American Indien, 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuban, Mexican, Puerto Rican, atc.) Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 8 Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) Federal Government Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) . Pages 1 and 2 should be fit thread of Health and Mental H fact; if from 27 is marked off fury or other traumatic aven Be Henry J. Giles Margaret Whitty 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) C. Hope Brown / Attorney 1003 K Street, NW, Suite 510, Washington, DC 20001 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 4 Donation 3/31/00 5 Other (Specify) Resurrection Cemetery Clinton, MD 21. Signature of Funeral Service-Licens 22. Neme end Address of Fecili Francis J. Collins Funeral Home, Inc. amo 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the math. Do not entar tha mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disaase or condition resulting in daath) /Medical , Acute Myocardial Infarction days Examiner Dua to (or as a consequance of): Examiner Atherosclerotic Heart Disease years The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immadiete causa. Enter Undarlying Cause (Disaase or Injury thet initiated evants rasulting in death) Last Due to (or es a consequenca of): physician Physician/Medical the Due to (or es e consequence of) 88 signed by the at d be detached for Pert it. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed has certificate Be Certification: To this

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: After s after death. filled in by within 24 hours a To the Funeral C Medical

senile dementia					
				24a. Was an autopsy performed?	24b. Wera autopsy findings evailable prior to completion of cause of death?  1  Yes 2 No
25. Wes case raferred to medical			26. Piaca of D	eeth (Check only ona)	
examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ 0	OOA Other: 4 Nursing	Home 5 ☐ Rasidence 6 ☐ Ott	ner (Specify)
27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigetion	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	rred
3 Sulcide 6 Could not be detarmined	28e. Pleca of Injury - At the building, etc. (Special	ome, farm, street, fectory)	ory, office	28f. Location (Street and Numer City or Town, State)	ber or Rurel Route Number,
				ce, end due to the cause(s) end m curred at the time, date end pleca,	
20h Signahus and title of godiling	110	2	Oc License number	20d Data signs	od (Month Day Veer)

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March 30, 2000

30. Name and addrass of person who completed cause of deeth (Item 23a) (Typa, Print)

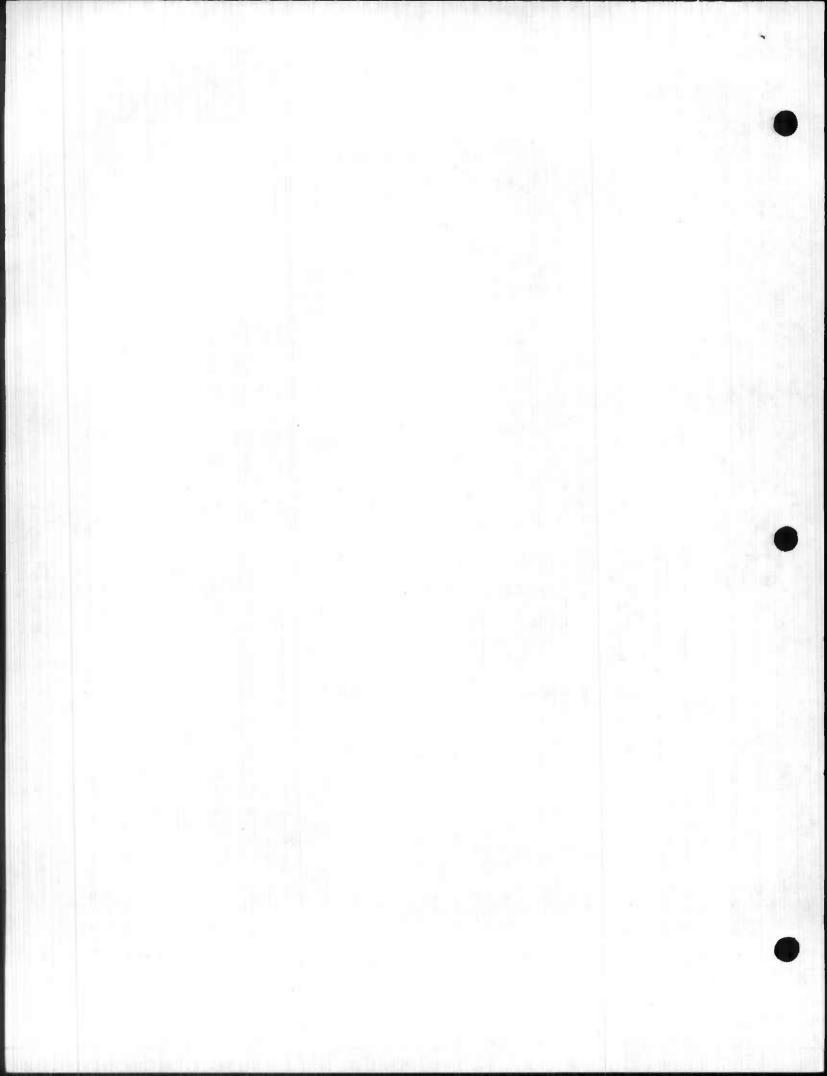
Peter M. Schissler, MD 7500 Greenway Center Drive, Greenbelt, MD 20770

31. Date filed (Month, Dey, Year) State

MAR 31

Registrar

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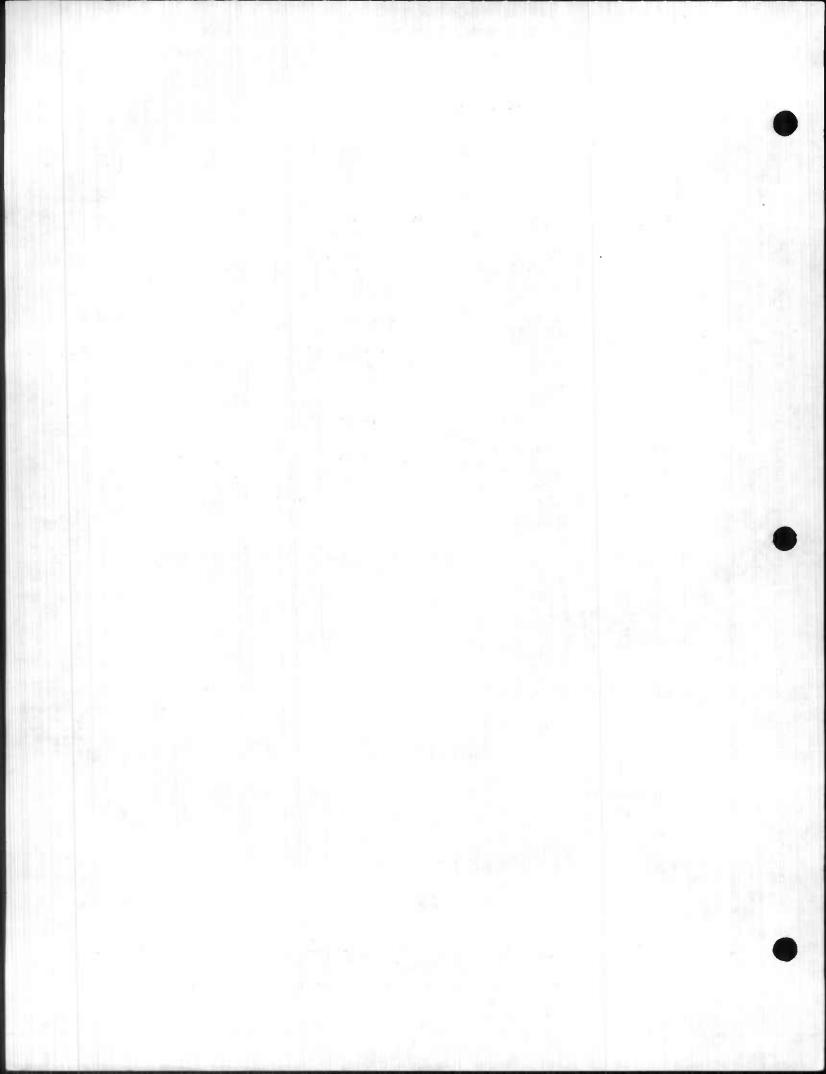
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			Cer	tificate of	Death	F	Reg. No.					
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Physician	MAUDE	L. GILL				march		000 6:41 a				
/Medical Examiner	4a Facility Nama (II not Institution, give	a street and number)			4b. City, Town, or I	ocation of Death	4c. County of	111111111111111111111111111111111111111				
All	Doctors Commo	wity Hospit	21		Lanhan	7	Prince	George's				
Funeral	5. Social Security Number 6. Se	ex 7. Aga (In yrs. la	nst birthday)		If Under 24 Hrs.			Birthplace (Stata or Forei Country)				
Director	577-52-3401	□M 20 F 814	Yrs.	Montha Days	Hours Min.	JULY 7	1915	WASH. D.C.				
9	Usual Residance of Dacedent											
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or 28a-f a be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?				
	12723 MILLST	REAM DR.		20	715		IT S	Λ.				
har death y later than 13 liner must	11. Maritel Stetus	12. Was Decedent Evar in U.S	3.   13. V			U.S.A.  Specify Yes or Norto Rican, atc.)  14. Race - American Indian, Black, White, etc.						
F. Far	1 Never Merried 2 Merried	Armed Forcas? 1 ☐ Yes 2 ☒ No				o Rican, atc.)	Black, 1	White, etc.				
D'SO IL	3 ☑ Widowed 4 ☐ Divorced	If Yas, Giva Year or Dates:	1	☐ Yas 2Ã No	Specify:		Specify:	WHITE				
P of the p	15. Decedent's Ed	Jucation	16a. Deced	lent's Usual Occup	pation		16b. Kind of Busin	ess/Industry				
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Physicien. 7 is marked other than "natural", or traumetic event, the Medical Exam To Be Completed by 1	(Specify only highest grades)		(Give I lifa. E	kind of work dona DO NOT use retire	during most of word)	nost of working						
The library mo	Elementery/Secondary (0-12)	Collega (1-4or 5+)		F.H.A. W	ORKER-RET							
D State O	17. Father's Name (First, Middle, Last)		-				Maiden Sumama)					
yland build be fit Mental H srked off affic even	HARRY	E. FEASTER		- 70	7	EONA	FERG	USON				
T MAN T	19a. Informent's Name/Ralationship (7		19b Mailin	n Address (Street			r, City or Town, Sta					
27 ls 27 ls c trau			- 0									
	GREGORY A. KIA		E CT., DI	Data 20c. Location - City or Town, Stata								
emit. Pages 1.s egartment of He moortant: if Item ny Injury or other tooks.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata cemetery, crematory or other place)											
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00580	2011/11/1hon	MOOOS	91 C	HAMBERS	FUNERAL H	HOMES .P.	A. RIVER	DALE, MD.207				
BOX 58/50, sath certificate be executed attending physician and for use as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Entar Undarrying Cause (Disease or Injury that initieted avents rasulting in death) Last	b. Veufij Due to (or Due to (or	as a consequence as a consequence	whice of:	fail	ure	and					
bat the deby the deteched	Part II. Other eignificant conditions or	d.	Iting in the ur	nderlying cause giv	ven in Part I.	23b. Did 1		  bute to the cause of deat   Probably 4 Unkno				
been s should							an autopsy med?	24b. Wara autopsy findings evailable prior to completion of cause of death?				
The lever ate hes page 2						10	as 2 No	1 ☐ Yes 2 ☐ No				
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To the Hospital or Attanding P within 24 hours after death to the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined		ma, farm, stre	eet, factory, office		28f. Location (S City or Tox		or Rural Routa Number,				
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	30. Name and address of person who of	completed dause of deeth dam	23a) (Type. I	Print)	10		1. 1					
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To the Hospital or within 24 hours after within 24 hours after To the Funeral Dir completely filled in Medical Cert	29b. Signatura and the of certifier	Alfarely A	23a) (Type, I		se number 9 4 2 9 3		3/27					

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

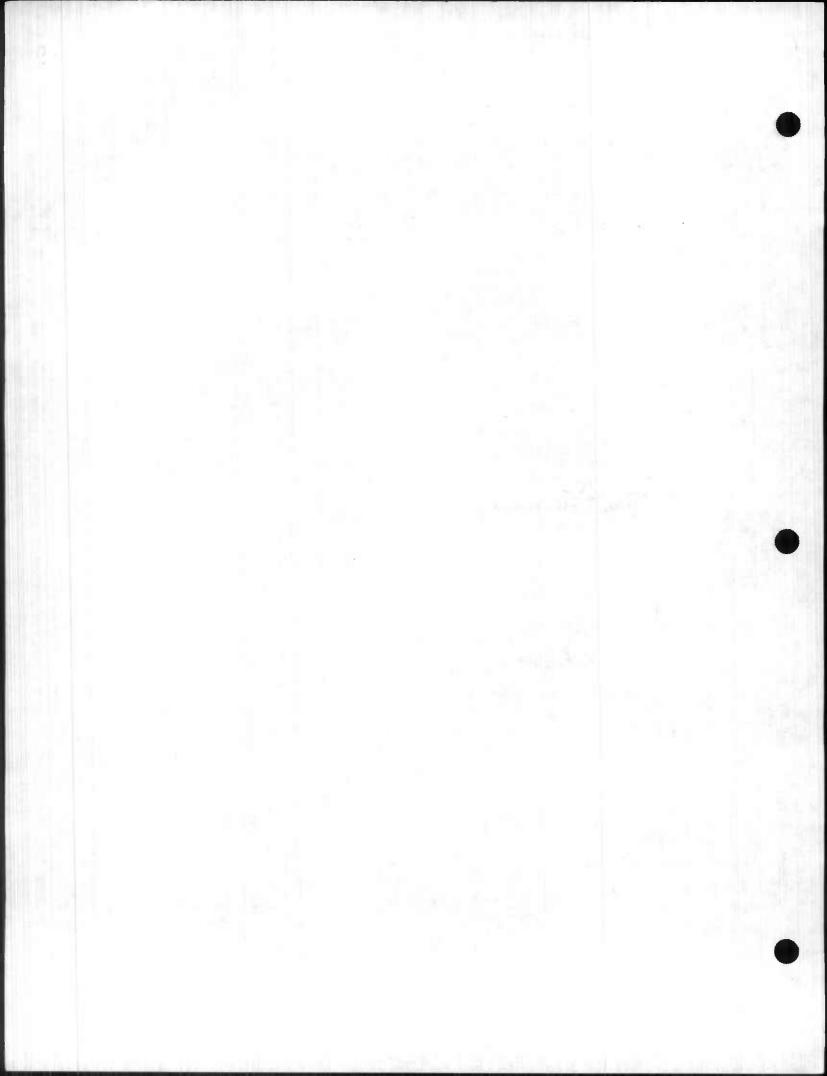
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Glotfelty, Jr. Joseph Thaddeus 23 March 2000 4:10 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring 307 Hillmore Drive Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Str. Country)
Oct. 12, 1914 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1₩ M 2□ F 577-12-7365 85 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show the Maryla must be notified 1 ☐ Yes 2K No Director Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 20901 307 Hillmore Drive USA flams 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 XNo Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Other than "n Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygiens Important; if Item 27 is marked other tha any Injury or other traumatic. Self-employed Electrical Contractor 18 Mother's Name (First Middle Meiden Sumame) 17. Father's Name (First, Middle, Last) 88 Carrie L. Browning Joseph T. Glotfelty, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Dorothy Glotfelty / Wife 307 Hillmore Drive, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of Oakland Fairview Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Oakland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 03/30/00 22. Name and Address of Fecility Hines-Rinaldi Funeral Home 21 Signature of Funeral Settle 11800 New Hampshire Avenue Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** adonocaronoma Immediate Cause (Final disease or condition resulting in death) /Medical nuo Examiner Due to (or as a consequence of) Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) for use as 60 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed has page 2 200 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Dinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attanding F s after death. After 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE F SENGSTACK 3929 M.D. FERRARA DRIVE WHEATON, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 28 Penera Registrar



State of Maryland / Department of Health and Mental Hygiene 00 11749

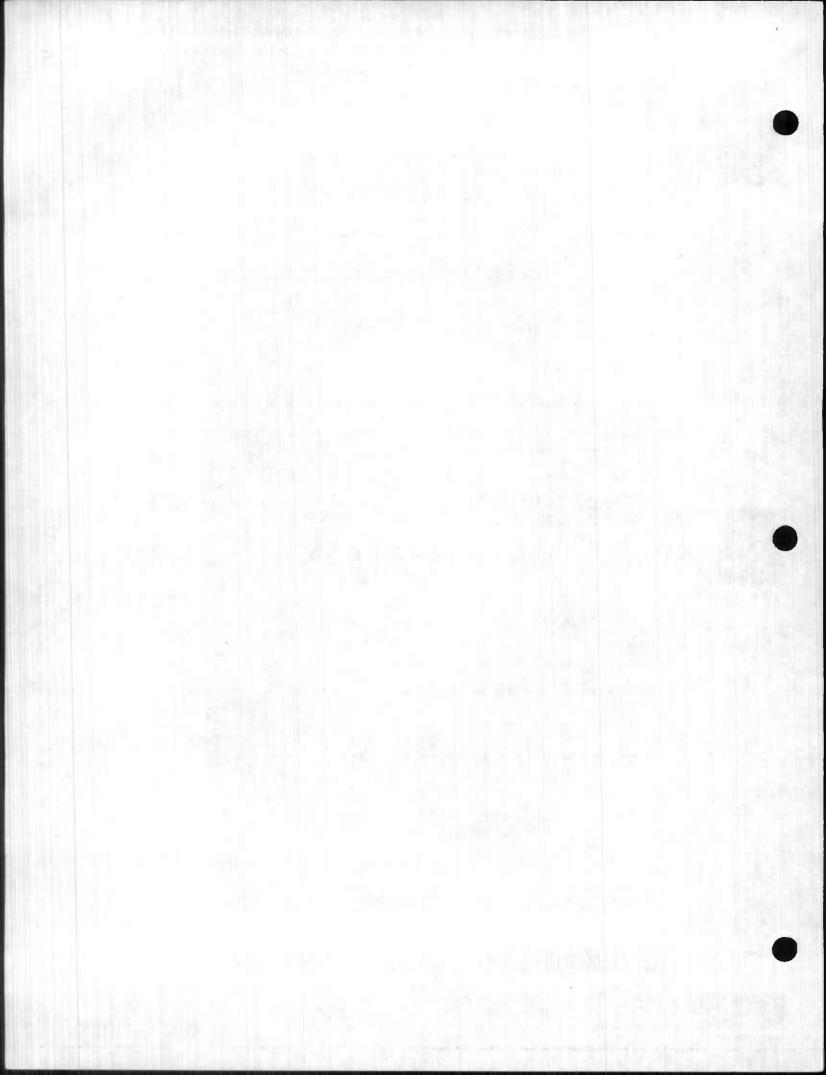
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edical miner	4a Facility Name (If not institution, g	rive street end nur	nber)				4b. City, To	wn, or Lo	cation of Death	4c. County			
iiiiiiici	Doctor's Hosp	ital					La	nham		Pri	nce G	eorge's	
ral	Sociat Security Number 6		7. Age (In yrs. last		If Under				8. Date of Birth	Vogel	9. Birthp	lace (State or Fo	reign
or	110 07 9358 Usuat Residence of Decedent	1□ M 2\ F	95	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jan. 27	,1905	Nort	h Carol	ina
	10a. State 10b. County		10c. City, To	own or Loca	ation	-					1	0d. inside City Li	mits
Director	Maryland Prince	George's		Gree	enbel							1 X Yes 2	] No
al Dire	3D Eastway Rd.				10f. Zip		770				nited States		
by Funeral Director	11. Merital Status  1 □ Never Married 2 □ Merried  3 ☒ Widowed 4 □ Divorced	Armed Fo	2 ₹ No		as Deced Yes, spec				ecify Yea or No- Rican, etc.)		e - Americ ck, Whita, v: W		
Completed	15. Decedent's (Specify only highest (	Education grade completed)	10	6a. Deceder (Give kii	nd of wor	k done	during mos	t of work		16b. Kind of B	usiness/inc	dustry	16
du	Elementary/Secondary (0-12)	College (1	-4or 5+)	lile. DC	O NOT us	e retire	ed)			27 / 1			
	12	5+		N/A	A		T 40 ** ·	-d- 64	15: A 11:14	N/A	1		
important: if item 27 is marked off any injury or other traumatic even page.	17. Fether's Neme (First, Middle, La (Unknown)	St)						nkno	e (First, Middle, I wn)	walden Suman	ne)		
	19a, Informant's Name/Retationship	(Type, Print)e o	al 1	19b. Mailing	Address	(Street	t end Numb	er or Run	al Route Number	City or Town	Stete, Zip	Code)	
	Jean Donnely Mac			3509	Reid	Ci	rcle,	Ft.	Washing	ton, M	D 20	744-6524	+
	20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3	20b. Place of Disposition (Neme cemetery, crematory or othe				ne of ther ple	ece)		Date March	20c. Location	City or To	wn, State	
1	4 Donation 5 Other (Special Supplied Letters of Supplied Letters o		Chesa							, MD			
3	Listed Tal	human	22. Namp prof Stephe 933 G				t Ave.	, Si	lver Sp	ring, M	ID 20	910	
ner	immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events.	a b	Due to (or as	a conseque	ence of):	ni	is	'L				2 de	4
or use a												o the cause of de	eath?
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certificate has been signed by the stretor, page 2 should be detached to Be Completed by Physic									24a. Was a perfor	in sutopsy med?	av	ere autopsy findi ailable prior to mpletion of ceus death?	
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0	25. Was case referred to medical	T					26. Plac	e of Deat	h (Check only or				
0	examiner? 1 Yes 2 No	Hospilat:	Inpatient 2 ER/	/Outpatient	3 DC	Ot A	ther		me 5 Reside		her (Specif	(v)	
-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date (Moni		b. Time of Injury		8c. Inju	ork?		28d. Describe h				
Certification:	3 Sutcide 6 Could not determine	be confirmed this Athense to stock feature efficiency					28f. Location (S City or Town		ber or Rura	al Route Number,			
edical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the ba	best of my knowled asis of examination ner stated.	dge, death o and/or inve	occurred estigation,	at the ti	ime, date ar opinion, der	nd place, ath occur	and due to the cred at the time, d	ause(s) and m late and ptace,	anner as s and due to	tated. the cause(s)	
Medical Ce	29b. Signeture and fittle of certifier		THE COLE		290	. Licen	se number		2	9d. Dete signe	ed (Month,	Dey, Year)	
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D	30. Name and address of person when Day Col. Co.	1	e of deeth (Item 23		rint) U Ye	シ,,	Insi	62	ecul			20776	2



State of Maryland / Department of Health and Mental Hygiene

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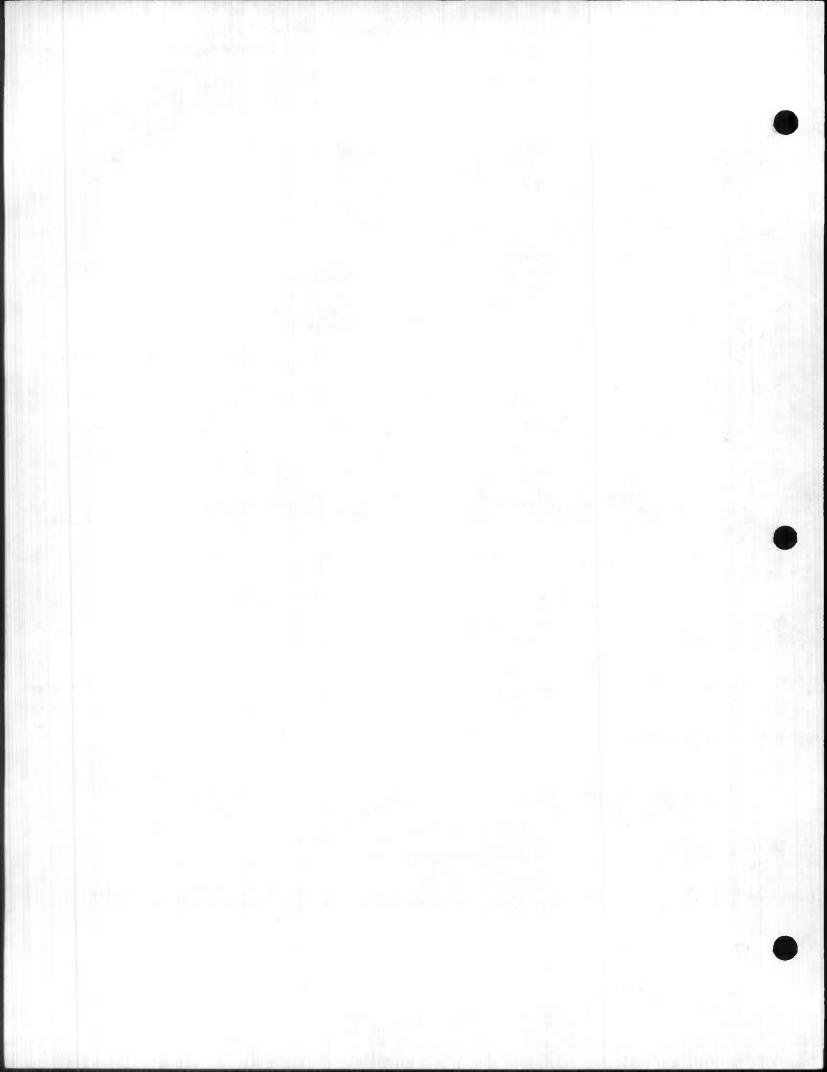
				Cert	ificate o	of Death			Reg. No.		
Physician	1. Decedent's Name (First, Middle, L							2. Date of De Month March		000	3. Tima of Death
/Medical										5:30 pm	
Examiner	4e Facility Name (If not institution, g 1111 Park Ave	#621				Balt	imor	e			
Funeral Director	444-26-7777	Sex 1X M 2□ F	Age (In yrs. last		If Under 1 You Months Da	ear If Under lys Hours	Min.	8. Dete of Bir March	4, Year 1931	9. Birthr Oklah	place (Stete or Foreign http:) OTTE
2	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, To	own or Loca	ation					1	Od. Inside City Limits
with the Maryland a or 28s-f show Libe notified at Director	MD N	/A	Baltin	more							1X Yes 2□No
th with the 23s or 1 unit be n	10e. Street and Number 1111 Park Ave #62		10f. Zip Code 21201				10g. Citizen of What Country? United States		ntry?		
020 us sher death with the Maryla at, or itsms 23s or 28s-t sho Examiner risest be notified at by Funeral Director	11. Maritel Status  1 Never Married 2 Married 3 Widowed 4 Divorced		s?		13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexicen, Puerlo R  1 ☐ Yes 2 [X]No Specify:			pecify Yes or No- o Rican, etc.)  14. Race - American Indi Black, White, etc.  Specify: White		etc.	
1 21215-0 ed within 72 ho sypiems. wir than "naturn it, the Medical.] Completed	15. Decedent's (Specify only highest g	rade completed)		6a. Decede (Give ki life. Do	nt's Usual Oc ind of work do O NOT use re	ccupation one during mos tired)	t of work	16b. Kind of Business/Industry			dustry
24 Marit	Elementery/Secondary (0-12)	College (1-4o	0 3+)	safe	ty Supe	rvisor			Steel 1	Mill	
Maryland 21215-0020 d 2 should be tiled within 72 hours at the and Mental Projects. 77 is marked other than "natural", or trearmetic event, the Medical Exam To Be Completed by F	17. Father's Name (First, Middle, La: Howard Green	st)				18. Mothe	er's Name	e (First, Middle	Meiden-Suman Sewel		
	19a. Informant's Name/Relationship  Jeffrey Grabelle /				Address (Stark Ave			nore, Mi	er, City or Town, 21201	State, Zip	Code)
Baltimore, N emit. Pages 1 and emit. Pages 1 and emortant: if them 27 ny injury or other it fixe.							City or Town, Stata				
Baltii Permit. 1 Departm Importer any inju	21. Signature of Funeral Service Licensee  22. Name end Address of Facility CAFA Stephen D. Lohnmann, P.A.										
	8717 Green Pastures Dr., Towson, MD 21286  23 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, Approximate Interval Between								Approximate interval Between		
Physician /Medical Examiner Examiner Examiner	Immediate Cause (Final disease or condition resulting in death)	a. <b>N</b> on	Small C Due to (or as			arinon	49			1	
x 6876( antificete be ling physicia se as the bur	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as e consequence of):										
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o. o tree sock the so	Part II. Other significant conditions	ne contributing to death but not resulting in the underlyIng ceuse given in Part I.					23b. Did tobacco use contribute to the cause			bebly 4 Unknown	
aw requires is been sign 2 should be									an autopsy omed?	av cc	dere autopsy findings railable prior to empletion of ceuse deeth?
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Vital F sician: The certificate irector, pag	25. Was cese referred to medical axaminer?	Manaital					of Deet	h (Check only	one)		
To To	1 Yes 2 No	Hospital:		/Outpatient	3□ DOA		ursing Ho		dence 6 Oth		fy)
Affer fune	1 Natural 5 Pending 2 Accident Investigati	on	Day Year)	Injury	М	Injury at Work? 1 ☐ Yes 2 ☐					
Divi	3 Suicide 4 Homicide  6 Could not be determined  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								al Route Number,		
DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		Physician: To the best arritner: On the basis and manner	of examinetion								
To the withing to the comp	29b. Signature and tille of certifier	-10	00-		-	ense number			29d. Date signs		
5-11	30. Name and address of person wh	Completed cause of	(death (tem **	(A) (Type B	(Inn)	5351	17	HILL I	Murch,	24,	2000
	ARNEL MENDOZA TA	AGLE MD	315 No	BETH C	4LVERT S	TREET B	ALTIA	norie, H	ARYLAND	2120	12
State	31. Date filed (Month, Day, Year)	32. Regis	strar's Signeture	4	lan	21					



State of Maryland / Department of Health and Mental Hygiene

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Documents Name of Parts Absolute And State Care Company  Robert L. Green  ## Facility Name of notes absolute, you seem and number)  ## Facility Name of notes absolute, you seem and number)  ## Facility Name of notes and states of the Part and a facility Name of notes and number)  ## Facility Name of notes and states of the Part and a facility Name of notes and number)  ## Facility Name of notes and number of the Name of Name o	cian				Certificate	oi Deatri	Reg.	No.	
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Social Sourchy Numbers   6. Sep.   17. Apply Priyor and Private of Private   1. Control   1. Con		4a Facility Name (If not institution,	give street and number)			4b. City, Town, or I			
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Sum   Superance   December   De	al	5. Social Security Number	S. Sex. 7. Age		Months D	ear If Under 24 Hrs.	8. Date of Birth	ar) 9. B	irthplace (State or Forei
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1. Martin Status   1. Martin S	P	10e. Street and Number			10f. Zip Co	de	/ 10g.	Citizen of What C	Country?
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10   10   10   10   10   10   10   10	e l	11. Marital Stalus		ver in U,S.	13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		
Social Creen   Social Creen   Social Company   Social C			d 1 □XYes 2 □ No	1947-	1 Yes 2	No Specify:			
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17. Fater's Name (First, Mode, Last)   18. Mohrets Name (First, Mode, Master) Address (Street and Number or Flural Route Name)   19b. Mailing Address (Street and Number or Flural Route Nambles, City or Town, State, Zp Code)   19b. Informatic Name Plateful Developed (Street and Number or Flural Route Namber or Flural Route Namber, City or Town, State, Zp Code)   14601   Deerhurst Terrace, Silver Spring, MD 20906.   20b. Majord of Deposition (South Sportson of Soliber (Sportson Soliber (Sports				16a.	(Give kind of work d	one during most of wor	king 16b	. Kind of Busines	s/Industry
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18. Morber's Name (First, Microbe, Last)   18. Morber's Name (First, Microbe, Maction, Maiden Stamman)   18. Morber's Name (First, Microbe, Name (First,	3			A	ccountant				Company
Sequentially list conditions are contributing to death but not resulting in the underlying cause given in Part I.		17. Father's Name (First, Middle, La	ast)			18. Mother's Ner	ne (First, Middle, Maid	den Sumame)	
198. Informant's Name/Relationship (Type, Print)   198. Mailing Address (Simest and Number or Rural Route Number, City or Town, State, Zip Code)   200. Method of Disposition ("Date of Heaven Cemetery")   4/1/00   5ilver Spring, MD   209   238. Pert   Steven the death of Confidence on the Confidence of Date of Heaven Cemetery   4/1/00   5ilver Spring, MD   209   238. Pert   Steven the death of Confidence on the Confidence of Date of Da		Cecil Green				Mary Ho	wse		
20c. Name of Disposition 10 Butes 2   Commentor 3   Removal from State 4   Consistion 5   Control of the Replace) 3. Signature s.F. General Service Licensee  21. Signature s.F. General Service Licensee  22. Signature s.F. General Service Licensee  22. Name and Address (Replace) 23. Part. Chief the disease, or ofmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  24. Part. Chief the disease, or ofmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  25. Part. Chief the disease, or ofmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  25. Part. Chief the disease, or ofmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  26. Due to (or as a consequence of):  27. Manner of Death 15. Ye ars.  28. Due to (or as a consequence of):  28. Was an autoppy partomed?  29. Was an autoppy partomed?  29. Was an autoppy partomed?  29. Part of Death 1   Yes 2   Yes   Ye		19a. Informant's Name/Relationshi	p (Type, Print)	19b	Mailing Address (Si	reet and Number or Ru	ral Route Number, Ci	ty or Town, State,	, Zip Code)
20. Heave of Disposition 1\( 2 \ Details of Disposition \ 3 \text{   Beaven \ Cemeter \   \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Betty J. Green /	Wife	1.	4601 Deerh	urst Terra	ce. Silver	Spring	MD 20906
Comparison of Silomer (Specify)   Comp				20b. Place of	Disposition (Name of	of .	Date 20c	Location - City o	or Town, Slate
231. Signature of Funeral Service Loanses  228. Part L. Effect the classes, or complete control of the state							4/1/00 Si	lver Sp	ring, MD
23a. Part   Sfirer the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate and Scalary (Final disease or conditions as a consequence of):	-		**						
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24a. Was an autopsy performed?  24b. Were autopsy indings available prior to completion of cause of death?  1   Yes 2   No   No   No   No   No   No   No	nysic	Tarrit. Other eigenhouse condition				e given in Part I.			
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25. Was case referred to medical examiner?  1	P	Tarin. Otto angument continue				e given in Part I.	1 ☐ Yea 24a. Was an a	2Å No 3□	Probably 4 Unknown.  Were autopsy finding available prior to completion of cause
1   Yes 2   No	2	Tan II. Otto angumesti continui				e given in Part I.	1 Yea  24a. Was an ar	2X No 3 utopsy 24b	Probably 4 Unknown.  Were autopsy finding available prior to completion of cause of death?
27. Manner of Death 1 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, Iarm, street, lactory, office 29e. Place of Injury - At home, Iarm, street, lactory, office 29e. Certifier (Check only one) 29e. Signature and title of certifier 29e. Signature and title of certifier 29e. License number 28e. Injury - At home, Iarm, street, lactory, office 28e. Injury - At home, Iarm, street, lactory, office 28e. Injury - At home, Iarm, street, lactory, office 28e. Injury - At home, Iarm, street, lactory, office 28e. Injury - At home, Iarm, street, lactory, office 28e. Injury - At home, Iarm, street, lactory, office 28e. Certifier (Check only one) 29e. Signature and title of certifier 29e. Signature and title of certifier 29e. License number 29d. Date signed (Month, Day, Year)	Completed by						1 Yes	2X No 3 utopsy 24b	Probably 4 Unknown.  Were autopsy finding available prior to completion of cause of death?
Second   Signature   Signatu	Be Completed by	25. Was case relerred to medical examiner?	Hospitel:			26. Placa of Dea	1 Yes  24a. Was an ai performed  1 Yes  with (Check only one)	2½ No 3□ utopsy 24b 2½ No	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  t □ Yas 2 ☒ No
29a. Certifler (Check only one)  29b. Signature and title of certifler  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be Completed by	25. Was case reterred to medical examiner?  1 Yes 2 No	1 LI Inpetient		tpatient 3□ DOA	26. Placa of Dea Other: 4 Unising H	1 Yes  24a. Was an arperformed  1 Yes  with (Check only one)  ome 5 \times Residence	2½ No 3 □  utopsy 24b  2½ No   6 □Other (Sp	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  t □ Yas 2 ☒ No
29a. Certifler (Check only one)  29b. Signature and title of certifler  29b. Signature and title of certifler  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be Completed by	25. Was case reterred to medical examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Pending	28a. Date of Injury (Month, Day	28b. 1	tpatient 3 DOA	26. Placa of Des Other: 4□ Nursing H Injury at Work?	1 Yes  24a. Was an arperformed  1 Yes  with (Check only one)  ome 5 \times Residence	2½ No 3 □  utopsy 24b  2½ No   6 □Other (Sp	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  t □ Yas 2 ☒ No
29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no	28a. Date of Injury (Month, Day)	Year) 28b, 1	tpatient 3□ DOA ime of 28c. njury M	26. Placa of Des Other: 4 Nursing H Injury at Work? 1 Yes 2 No	1 ☐ Yes  24a. Was an ai performed  1 ☐ Yes  ath (Check only one)  tome 5 ☒ Residence  28d. Describe how in	2k No 3 Ustopsy 24b 2k No 2k No Sprinjury occurred	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  t Yes 2 2 No
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  D 44157  March 30, 2000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	28a. Date of Injury (Month, Day)	Year) 28b. 1	tpatient 3□ DOA ime of 28c. njury M	26. Placa of Des Other: 4 Nursing H Injury at Work? 1 Yes 2 No	1 ☐ Yes  24a. Was an air performed  1 ☐ Yes  ath (Check only one)  tome 5 ☒ Residence 28d. Describe how in  28l. Location (Stree)	2K No 3 Unitopsy 24b 2K No 2K No 6 Other (Sp. njury occurred	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  t Yes 2 2 No
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D 44157 March 30, 2000  30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)	Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 3 Suicide 6 Could no determin  29a. Certifier 1 Certifying (Check only 2 Medical Ex	1 La Inpetient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.  Physician: To the best of taminer: On the basis of etaminer:	Year) 28b. 1 y - At home, Ia (Specify)  my knowledge xamination and	tpatient 3 DOA Time of 28c. njury M rm, street, lactory, of	26. Placa of Des Other: 4 Nursing H Injury at Work? 1 Yes 2 No fice	1 ☐ Yes  24a. Was an arperformed  1 ☐ Yes  ath (Check only one)  tome 5 ☒ Residence  28d. Describe how in  28l. Location (Streer City or Town, St.	2k No 3 utopsy 24b 2k No	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  t □ Yas 2 ☒ No pecify)  Rural Route Number, es stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Pending investiga   2   Accident   3   Suicide   4   Homicide   4   Homicide   29a. Certifier (Check only one)	1 La Inpetient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.  Physician: To the best of taminer: On the basis of etaminer:	Year) 28b. 1 y - At home, Ia (Specify)  my knowledge xamination and	tpatient 3 DOA ime of 28c. njury M rm, street, lactory, of , death occurred at the	26. Placa of Des Other: 4 Nursing H Injury at Work? 1 Yes 2 No fice ne time, date and placa my opinion, death occur	1 ☐ Yes  24a. Was an arperformed  1 ☐ Yes  ath (Check only one)  tome 5 ☒ Residence 28d. Describe how in  28l. Location (Stree City or Town, S)  and due to the cause rred at the time, date	2k No 3 utopsy 24b 2k No	Probably 4 Unknown.  Were autopsy linding available prior to completion of cause of death?  It Yes 2 No Decity)  Rural Route Number,  es stated.  us to the cause(s)
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31. Date filed (Month, Day, Year) 32. Registrar's Signature	edical Certification: To Be Completed by	25. Was case relerred to medical examiner?  1   Yes   2   No  27. Manner of Death 1   Natural   5   Pending investiga   2   Accident   3   Suicide   4   Homicide   4   Homicide   29a. Certifier (Check only one)   2   Medical Example   Medical Example   29b. Signature and title of certifier   1   1   1   1   1   1   1   1   1	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  Physician: To the best of tamilner: On the basis of e and manner state	Year) 28b. 1 In y At home, Ia (Specify) my knowledge xamination and d. 11 Road	tpatient 3 DOA Time of 28c. njury M Trm, street, lactory, of 29c. Li 29c. Li Type, Print)	26. Placa of Dea	1 Yes  24a. Was an arperformed  1 Yes  ath (Check only one)  ome 5 N Residence 28d. Describe how in  28l. Location (Stree City or Town, St.)  , and due to the causerred at the time, date  29d.  Mar	2k No 3 utopsy 24b 2k No 3 2k No	Probably 4 Unknown  D. Were autopsy linding available prior to completion of cause of death?  It Yes 2 No Decity)  Prural Route Number,  es stated.  us to the cause(s)



State of Maryland / Department of Health and Mental Hygiene

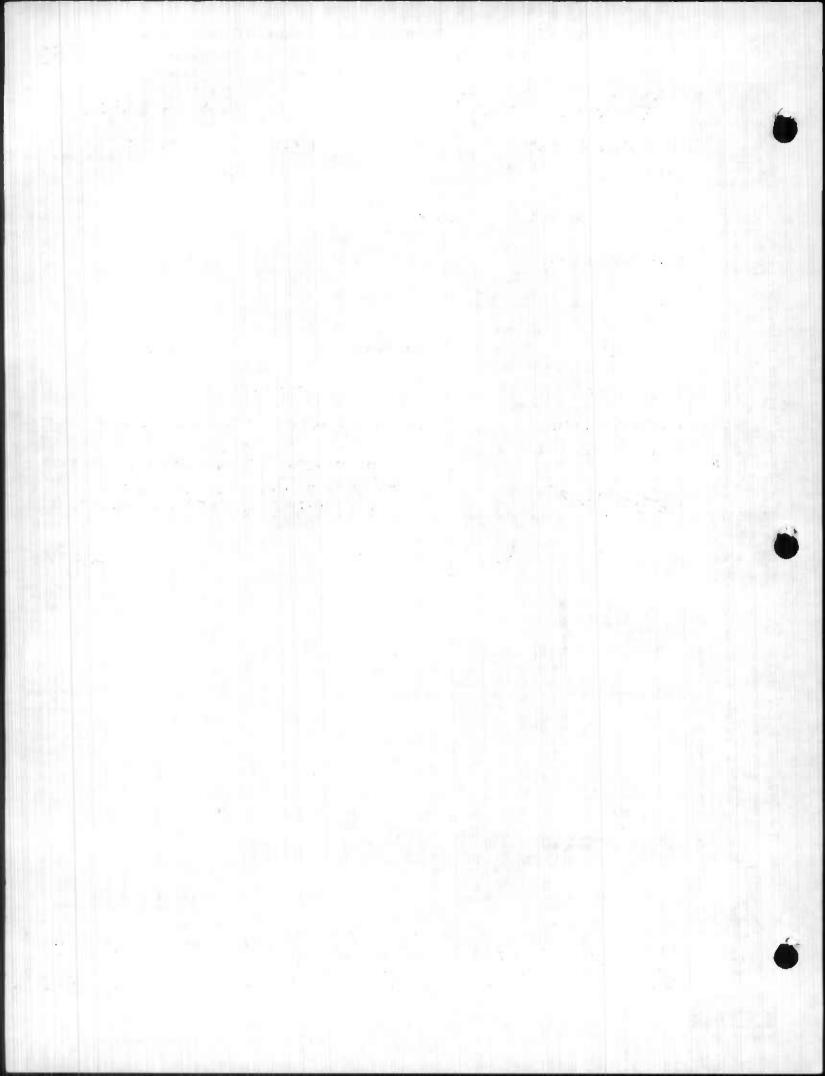
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				-	

				Certificate	of Death	7	Reg. No.	11175
Physician	Decedent's Name (First, Middle, L.	Dennett	e Arth	ur Harro	od	2. Date of Month March	Death	3. Time of Death 2000 10:24 P.M
/Medical Examiner	4a Facility Name (If not institution, git Holy Cross Ho					own, or Location of D	Mon	tgomery
Funeral Director	137-14-9829	MIN OFF	(In yrs. lest birt		Year If Unde Deys Hours	Min. 8. Dete of (Month, Augus	Birth (Day, Year) 1917	9. Birthplace (State or Foreign Country) PA
the Maryland 286-1 show notified at rector	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town		lashingt	con, D. C.		10d. Inside City Limite 11∑ Yes 2 ☐ No
E 88 0	10e. Street and Number 1621 Varnum St	reet N. W.		10f. Zip C	ode 20011-	-4205	10g. Citizen of USA	•
72 hours after death v natural, or here 23s ited Examiner must sted by Funeral	11. Marital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 N Yes 2 N If Yes, Give Year or Detes:		If Yes, specify	. Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☒ No Specify:			ce - Americen Indien, ck, White, etc. <sub>5y:</sub> Black
led within 72 ho tygiene. Instrument of the Medical.	15. Decedent's E (Specify only highest gr Elementary/Secondery (0-12)			Decedent's Usuel (Give kind of work life. DO NOT use	done during mo retired)			usiness/Industry
id be filed wit ental Hygiens had other that ic event, the O Be Corr	17. Father's Neme (First, Middle, Las Irvin Harrod	5 +	' Ma	nagement		ner's Name (First, Mid Viola Car		
and 2 should allth and Me 27 is mark or traumatio	19a. tnformant's Neme/Reletionship Phyllisolive Har			_		ber or Rural Route Nu	mber, City or Town	, State, Zip Code) C. 20011-4205
Pages 1 ament of He ament of He mury or other	20a. Method of Disposition 1 ⊠Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Special		cemeter	Disposition (Name y, cremetory or othe ton Natio	er plece)	Dete 4/10/00		- City or Town, State ton, Virginia
Depart Depart Import any inj	21. Signeture of Funeral Service Licensee  22. Neme end Address of Fecility Joseph Gawler's Sons 5130 WI Ave. NW Washington, D.C. 200							
death certificate be axecuted e attending physician and od for use as the burial-transit sician/Medical Examiner	23e. Pent1. Enter the disease, or con shock, or heert feilure. List only Immediate Cause (Finel disease or condition resulting in deeth)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	Cardia  Cardia  b. Hypert	c Arres Due to (or es e c c Arrhy Due to (or as e c	t onsequence of): thmia onsequence of): Cardiovas				Approximete the transfer of th
d by the							ontribute to the cause of death?  3 Probably 4 A Unknow	
The law requires that the sale has been signed by the page 2 should be detached.	brain					24a. V	Ves an autopsy erformed?	24b. Were eutopsy findings availeble prior to completion of cause of death?
detan: The la certificate ha rector, page.	25. Wes case referred to medical				2ê Die		Yes 2K No	1 ☐ Yes 2 ☐ No
After this funeral difference of the state o	S. Wes case referred to medical examiner?   26. Place of Deeth (Check only one)							rred
To the Hospital or Attending Physician: The law requires the within 24 hours after deeth.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be to Medical Certification: To Be Completed by		iyelcian: To the best of niner: On the basis of and menner stel	exemination and					enner es stated. end due to the cause(s)
(2)12	29b. Signature and title of certifies 3	for a	m		D 5226	1		ed (Month, Day, Year)
State	Alan Segal, M. I	). 1299 L 32. Registre	amberto	n Drive	Silver	Spring, 1	MD 209	02



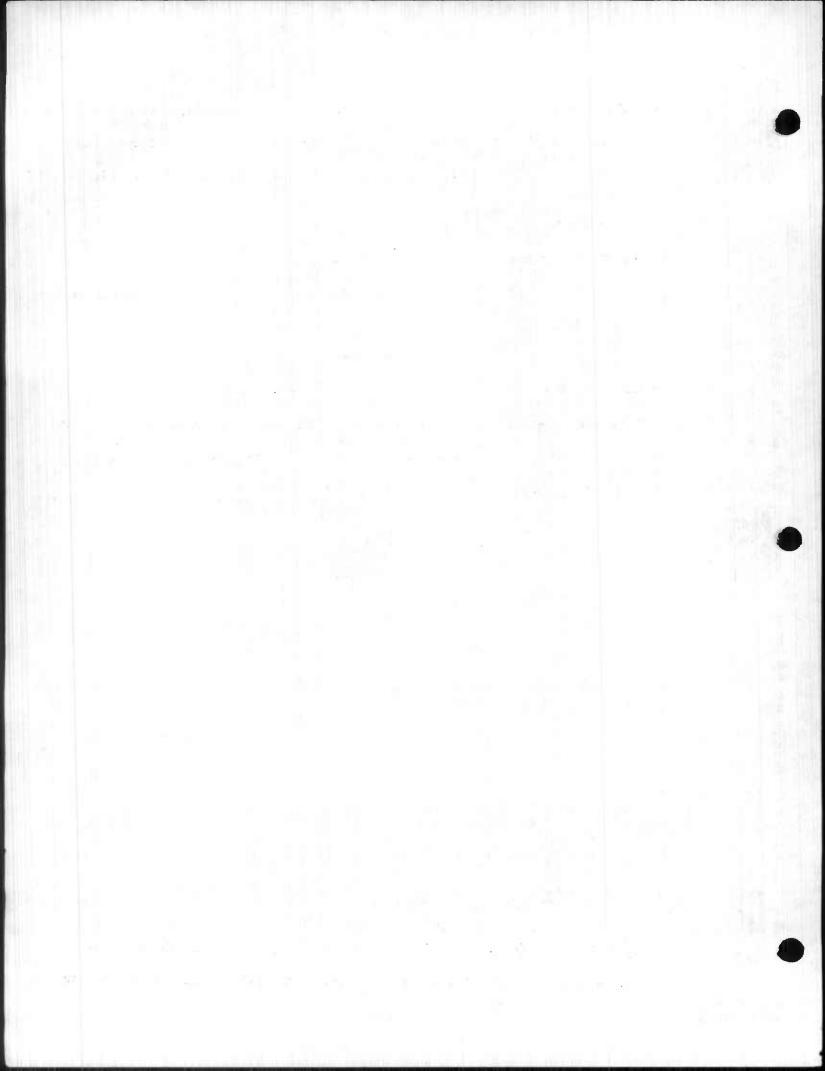
# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 1753 Certificate of Death

										Death		Reg. No.	0 1	1/0	, 0
	Physician /Medical		He	e (First, Middle, Last	He	77					2. Dete of Do Month	24 T	100°C	3. Time of 7:3	Peath
	Examiner	4		If not institution, giva		)				4b. City, Town, or	Location of Deal				
	Funeral Director		579.86.9	745			last birthday,	If Und Months	er 1 Year Days	OLNEY If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di APR 1	th ly, Year)	9. Birthol Count ENGLA	ece (State o	or Foreign
	hend www		Jsual Residence of Oa. Stata	10b. County		10c. Cit	y, Town or L	ocation					10	d. Inside C	ity Limits
	th with the Maryland 23a or 28a-f show ust be notified at		MD	MONTGON	ERY	OLL	VEY							1 X Yes	2 🗆 No
	or 28a-f o	1	0e. Street and Nu	mber				10f. Z	ip Code			10g. Citizen of	What Count	ry?	
	5 8 3			BLES COURT	12. Was Decedent	Ever in 11	6 42		0832	Jianania Origin? /6		USA 14 Be	ce - Amarice	n fodian	
020	ors after		Marital Status     □ Never Marr     Widowed	ied 2 Married	Armed Forces'  1 Yas 2 V  If Yes, Give  Year or Dates:	? No		If Yes, sp		Hispanic Origin? (S an, Mexicen, Puerl Specify:	o Ricen, etc.)		y: WHIT	itC.	
21215-0020	ed within 72 hours lygiene. In the linetural; of, the literal and Completed by		Elementary/Seco	15. Decedent's Educify only highest grad	cetion e completed) College (1-4or	5+)				pation during most of wo d)	king	16b. Kind of E		ustry	
	other th	3	7 Father's Name	(First, Middle, Last)			HOME	MAKE	Κ	18 Mother's Na	na (First Middle				
land	Mental H Mental H arked ott atic ever	1	SIMON EI			18. Mother's Nama (First, Middle, Maiden Sumame)  FANNY NIEMAN							,,,,		
Maryland	should Manual	i and		ame/Relationship (T)	rpe, Print)		19b. Mail	ng Addre	ss (Stree	and Number or Ri		Code)			
	Page Hitting	RODNEY H			Tan -				EATRE CIR			132			
Baltimore,		2		position □Cremation 3 □F 5 □Other <i>(Specify)</i>	lemoval from State	20b. Place of Disposition (Name of cemetery, crematory or other place)  MOUNT LEBANON CEMETERY  Date MARCH  MOUNT LEBANON CEMETERY  27, 2000 ADELPHI, MARYLAN								)	
Balti	Departm Departm Importa any inju	Department Department of Important: If any injury or pince.	21. Signatura of Fu	neral Sarvice Licens	80	Pion	2	2. Name	and Addre	ess of Facility  GEL FUNER					REU
	Physician /Medical Examiner		23a. Part1. Entar ti shock, or hea immediate Cause disease or condition resulting in death)	he disaasa, or compl rt failure. List only of Final	cations that cause ne cause on each	0	n. Do not en	ter the m	ode of dy	VIILE PIK	c or respiratory a	arrest,	C	Approxima Interval Bel Onset and	tween
x 68760,	artificete be executed ing physician end a as the burial-transit		Saquentially list co f any, laading to in ceuse. Enter Unde Cause (Disease or that initiated events resulting in death)	nditions, nmediate rhyling Injury	) )		or as a conse								
Вох	the attending the for usa as Vaician/Me													.0.	-1-1-1-0
, P.O.	\$ 5° C	P	art II. Other signif	icant conditions cor	tributing to death I	but not res	ulting In the u	inderlying	cause gi	ven in Part I.		23b. Did tobacco use contribute to		- 7	
Records,	aw requires to been so 2 should bleted	-								24a. Wa	rlormed? 8		re autopsy illable prior npletion of leath?	to	
R	The la										1 🗆	Yas ZZINO	1 🗆	Yes 28	(No
Vital	entific ector.	2	25. Wes case refer examiner?	4	lospital:				Ot	hor:	ath (Check only	111111111111111111111111111111111111111			
of	this aldi	-	1 ☐ Yes 25. 27. Manner of Deat	NO	28a. Date of Inj	ury	ER/Outpatle		28c. Inju	ry at	1	how injury occu		')	
Division	To the Hospital or Attending Physhin 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral Medical Certification:	1 Matural 5 Pending Invastigation 2 Accident 3 Suicida 4 Homicide 1 Homicide 2 Matural 1 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						rk7 ]Yes 2□No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Routa Number, City or Town, State)						
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in Medical Cert	29a. Certifier (Check only one)  12 Cartifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  12 Madical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.													
	To within								Dense number 29d. Date signed (Month, Day, Year)  Multip 25, 200						
	State		31. Date filed (Mon	th, Day, Year)	mpleted ceuse of 32. Regist	Jul	0 1	8not)	1 1	Ma)	bp-/	70,0	Jluz,	gud ?	2833



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 101

Dhusi	lo-	1. Decedent's Nama (First, Middle,	, Lest)					2. Date of D			Time of Deeth			
Physic /Medi		ADDIEMAE HO	LDER						28, 2000		ry County thplace (State or Foreign pointy) hington, DC  10d. Inside City Limits 1 Yas ANO puntry?  Arican Indien, i.e., etc.  1casian  /Industry  me  Zip Code)  and 20854 Town, State irginia			
Exami		4e. Fecility Nama (If not institution,		ar)			4b. City, Town, or	Location of Dee	th 4c. County		Lill AM			
		Manor Care H	ealth Care	Sarwi	icac		Potomac		Monte		7			
Funeral					lest birthday)	il Undar 1 Yaar	Il Under 24 Hrs		rth .	9. Birthplace	(Stete or Foreig			
Director	_	225-90-3548 Usuai Residence of Decadent	1 □ M 2 <b>X</b> F	95	Yrs.	Months Days	Hours Min							
me 23a or 28a-f show	J.	10e. Stata 10b. County		10c. Cit	y, Town or Loca	ation								
or 28a-f	Director	Virginia Fairfa  10e. Street end Number	ax		Reston	10f. Zip Coda			10g. Citizan ol		1 185 2 E   N			
23a c	ie C	11742 Great Owl	Circle			2010/	1160		TTOA					
Items 2	Jer	11. Marital Status	12. Was Decedar	nt Ever in U,	S. 13. W	20194 as Decedent of	-1168 Hispanic Origin? (S ben, Mexican, Puer	Specify Yas or N	USA 0- 14. Rad	ca - Amarican In	dien,			
	by Funeral	1 ☐ Never Marriad 2 ☐ Marrie 3 📉 Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yes 2 ☑  if Yes, Give  Year or Detes	No		Yas, specify Cut  ☐ Yes 2  ☑ No		to Rican, atc.)		an ol What Country?  A. Raca - Amarican Indien, Biack, White, etc.  Apecity: Caucasian  d ol Business/Industry  Own Home  umeme)  Town, Stete, Zip Code)  Maryland 20854  ation - City or Town, State  and, Virginia  gton, Va. 22203  Approximate Interval Between Onsat end Death				
ene. than "natural", or ite ne Madical Examine	Completed	15. Decadant's (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4o	or 5+)	(Give k	ent's Usuel Occu ind of work done O NOT use retire	during most of we	rking 16b. Kind ol Business/Industry  Own Home						
	5	10			Ho	memaker			Owi	Home				
nd Mental Hygiene. marked other than imatic event, the M	Be (	17. Fether's Nama (First, Middla, L.	.ast)				18. Mother's Na	me (First, Middle	, Maiden Sumer	ne)				
ked ked ic e	ToE	Arthur E. Dowe	e11				Addia	t of working						
and Men Is marke aumatic	-	19e. Informent's Name/Reletionship (Type, Print)  19b. Melling Addrass (Street								Stete Zin Code	e)			
Deportment of Health and Mental Hyg Important: if Item 27 is marked other any Injury or other traumatic event, once.  To Be C							,							
	Robert K. Holder - Son  20e. Method of Disposition  1 X Buriel 2 Cremetion 3 Ramoval from State  7831 Whiter  20b. Place of Disposition (Name o cematary, cremetory or other					Whiteri tion (Name of atory or other pla	m Terrac	Date	mac, Mai 20c. Location	City or Town, S	th  Ty County  Ithplace (Stete or Foreign  Ind. Inside City Limits  I Yas 2 No  10d. Inside City Limits  I Yas 2 No  Dountry?  Industry			
		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Mid	lland Co	emetery		3/30/00	Midland	. Virgi	I:15 AM  Image: Deeth  Image:			
Depent Import any inj		21. Signature of Funeral Service Li	icensee /		22.1	Name end Addr	ess of Facility			of Deeth of				
SEE		MAKKAPM	1190				on Funera							
hysician		23a. Part1. Entarthe disease, or o	complications thet cause	ad tha death	n. Do not anter	the mode of dy	Fairfax ing, such es cardia	Drive-	Arlingto errest,	App	roximate			
Medical		23a. Part1. Entar the disease, or o shock, or he at a lure. List of limmediate Cause (Finel disease or condition	O		n. Do not anter	the mode of dy	ing, such es cardia	c or respiretory e	errest,	App	roximate rval Between			
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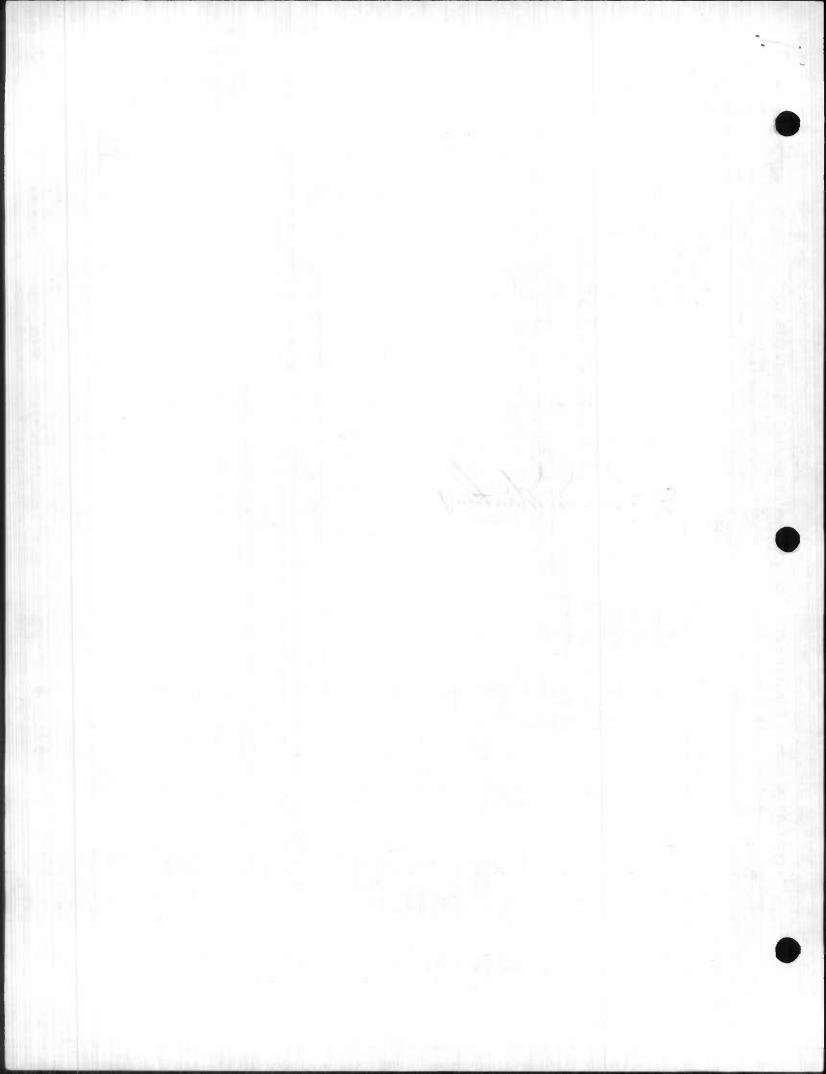
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State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Ma	Laparmont of reasin and wortis inggene. Important: if tern 27 is marked other than "natural", or items 23s or 28s4 s any injury or other traumatic event, the Medical Example must be notified.
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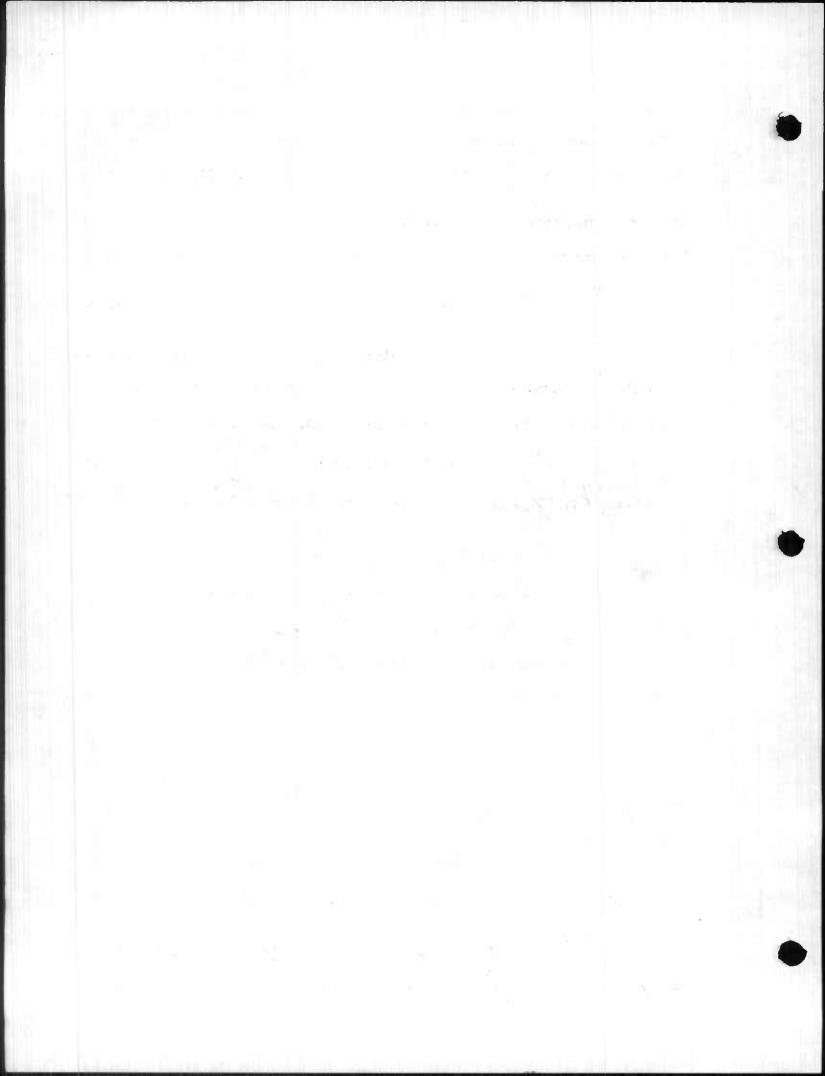
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Function	5. Social Security Number		Age (In yrs. last birthe	day) If Under	1 Year	If Under 24 Hrs.							
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 29 ROBERT C. HOWES, SR. 2000 16:46 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery Montgomery General Hospital If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) Sept. 22 1934 If Undar 1 Yaar 9. Birthpiace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Maryland 1**M** M 2□ F 65 217-30-7000 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 6 No Maryland Howard Highland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20777 United States 12815 Hall Shop Road Race - American Indian Biack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 Naver Married 2 Married White 1 ☐ Yes 2 ☑ No Specify Specify 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) Coilege (1-4or 5+) Public Utility Maintenance 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Nama (First, Middla, Last) Cecil Helen Marie Musgrove Howes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20777 12815 Hall Shop Road, Highland, Maryland Grace Howes / Wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 4/1/00 Clarksville, Maryland Linthicum Chapel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber P.O. Box 5038, Funeral Home Laytonsville, Maryland 20882 23a. Part1. Enter the dis-shock, or hear failu se, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only ona cause on each line. Approximete Intervai Batween Onset and Death Immediata Cause (Fina disease or condition resulting in death) Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): 0 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1€ Yes 2 No 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes > No 1 ☐ Yes 2 ☐ No (Specify)

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the a signed by the peen has e 2 certificate has lirector, page 2 director. or Attending Physician: this After this funeral death. ofter death.

Director: A To the Hospital or within 24 hours eft To the Funerel Di completely filled in

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manylen Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show important: If item 27 is marked other than "naturel", or items 23s or 28s-f show important if items 27s or 28s-f show important in the modified at once in the increase of the profiled at once in the modified at once in the increase in the in

**Physician** /Medical

Examiner

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Certification:

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Baltimore, Maryland 21215-0020

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25. Was cese referred to medical				26. Place of De	ath (Check only one)
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27. Manner of Death   Natural   5   Panding     Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Panding     Panding   Pandin		28b. Time of Injury		Injury at Work? 1 Yes 2 No	28d. Describe how injury occurre

determined 4 Homicide

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

non

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2 0 00 29c. Licansa number

29b. Signature and title of certifier

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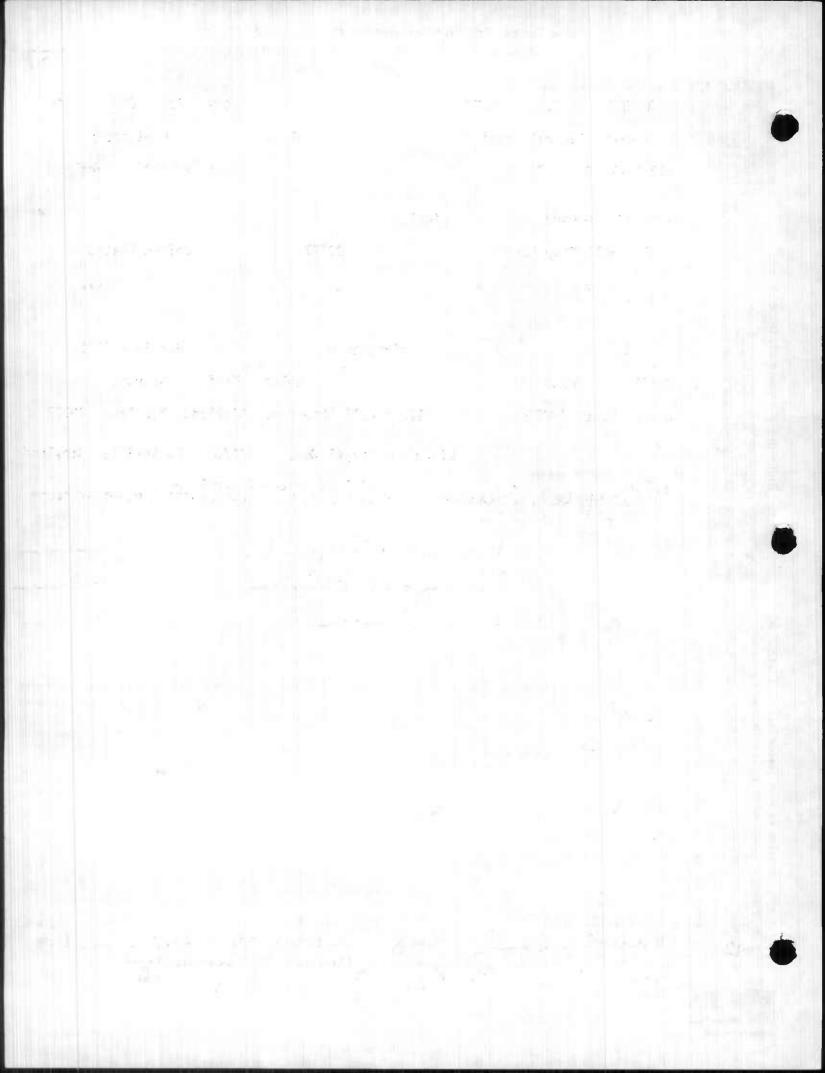
wed M.D.

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 18111

CONNOlly, J.

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 31

12



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

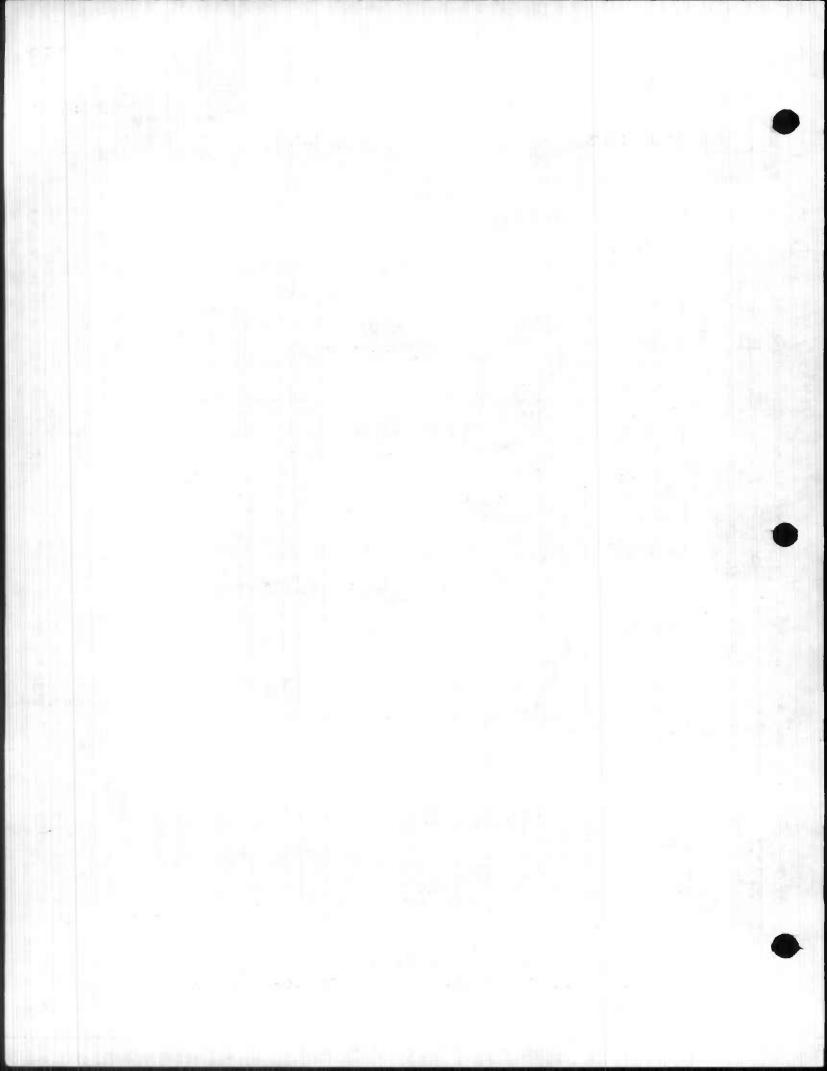
State of Maryland / Department of Health and Mental Hygiene 00 11758

						C	Certifica	te of	Death			Reg. No.		1 1 1	00
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	Physician /Medical	VAUGHN		EUGENE	HAV	NEN					MARCH		2000	3:00	AM
	Examiner	4e Facility Name (If not ins	titution, giv	e street and num				4	4b. City, Tox	wn, or L	ocation of Dea		ty of Death		_nu_
		CIVISTA MEDICAL			* 4 //	for A friedly	de al Millade	r 1 Year	IAPIAT		Doto - (D	CHAR			
< S	Funeral Director	5. Social Security Number 579-34-0978		M 2□F	7. Age (In yrs. 70	Yn	Months		Hours	Min.	8. Date of B (Month, D Feb. ]	4, 1930	9. Birth	olace (State ontry) OWd	or Foreign
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+	Iter death v	11. Marital Status		12. Wes Dece		,S.	13. Was Dece	dent of H	lispanic Orig	gin? (Specify Yes or No- , Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.					
	020 urs sher ar, or he Examine by Fu			Armed For 1 X Yes If Yes, Give Year or Da	2□No 10	949-	1 ☐ Yes		Specify:	, rueito	rican, etc.)	Speci		nite	
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AUGH	7 Steam 27 other tr	Joseph Ingval Havnen  19a. Informant's Name/Relationship (Type, Print) Dorothea Havnen/Wife  Dorothea Havnen/Wife  Dorothea Havnen/Wife  Dorothea Havnen/Wife													
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	Division o To the Hospital or Attending Ph within 24 hours after deadless to the Funeral Director: After th completely filled in by the funeral Medical Certification:			ysician: To the ballinar: On the ball	sis of examina										(s)
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1	F S F O	<b>)</b> (\/,	All	11								3/29	7/00	1	
		30. Name and address of person who completed causa of death (Item 23a) (Type, Print)							10	1					
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DHMH 16 Ray 6/95

Registrar

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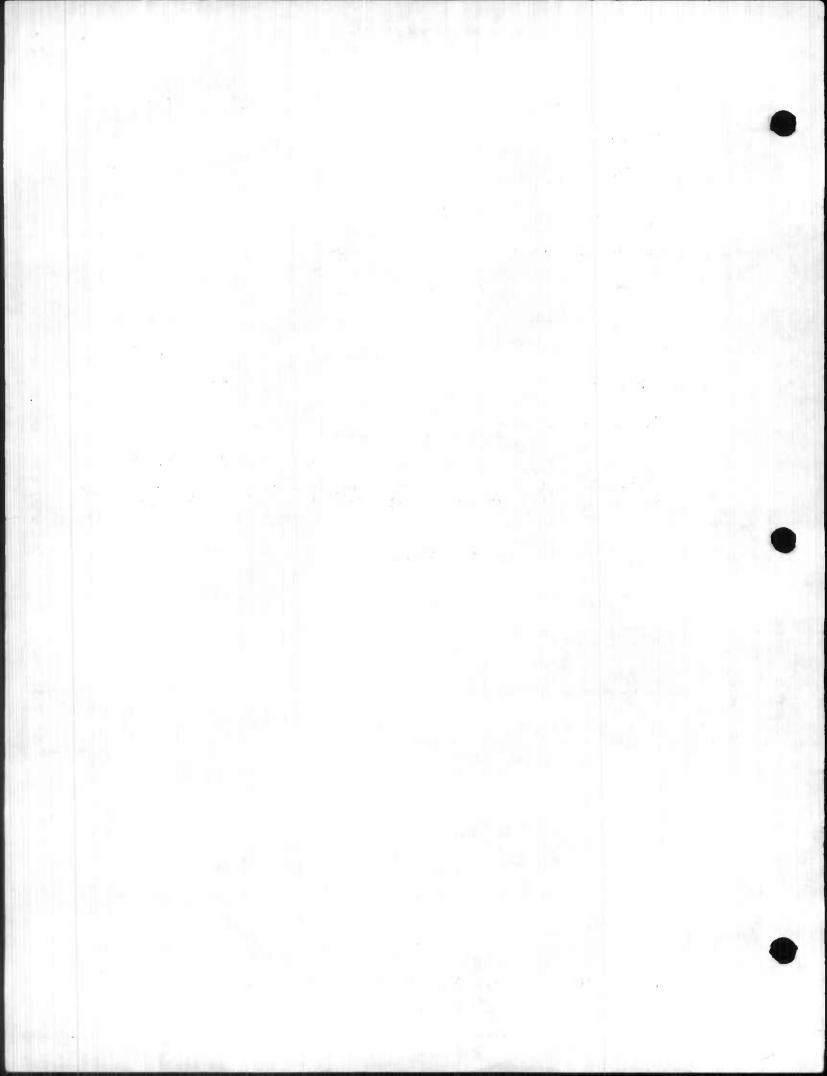
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State of Maryland / Department of Health and Mental Hygiene

AMEND#11#PER INFMNT. G784 6-9-2000 JAB

00 11759.

	THE THE THE THE TANK THE	0704 0-7-	2000 JA	<sup>b</sup> Cei	rtificate	e of	Death			Reg. No	١,		1100	
Physician	1. Decedent's Neme (First, Middle,								2. Dete of De Month	eth De	y	Year	3. Time of Death	
/Medical	RICHARD HENDERS								1ARCH 2	28,	2000		1:02 PM	
Examiner	4a Facility Name (If not institution, 12168 GILLESPIE	CIRCLE					WALDO	RF	ation of Deet			of Deeth RLES		
uneral irector	219-46-8403	3. Sex 1 M 2 □ F 7.	Age (In yrs. last	Yrs.	Months	Days		24 Hrs. Min.	APRIL	28,	194	9. Birthple 6 WASF	ca (Stete or Foreign TINGTON DC	
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oer must be notified at uneral Director	10e. Street and Number		MALI	DONI	10f. Zip	Code				10g. Cit	izen of V	Vhat Country	/?	
ner must be uneral D	12168 GILLESPIE	CIRCLE			20	060	l			U.:	S.A.			
by F	11. Maritel Status  *** Never Married 2   Merrie 3   Widowed 4   Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? (X) No		Wes Deced f Yes, spec			gin? (Spec n, Puerto F	cify Yes or No lican, etc.)	)-		e - American k, White, etc WHIT	c.	
pete	15. Decedent's (Specify only highest		1	6a. Deced	lent's Usua kind of wor	d Occu	pation during mos	t of workin	a	16b. K	ind of Bu	siness/Indu	stry	
Completed	Elementery/Secondery (0-12)	College (1-4	or 5+)		INST	e retin	ER				CAR			
Department of Neath and Mental Important if Hen 27 is marked of any injury or other traumatic even XX	17. Father's Neme (First, Middle, La CLARENCE HENDER	•	18. Mother's Neme (First, Middle, Maiden Sumer MARGARET TEWALT				Sumem	10)	Z					
	19a. Informant's Name/Reletionship				oss (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) NT PLACE, APT. 103, WALDORF, MARYLAND 20									
		DN/STEP-DA					LACE,	APT.		20c. Location - City or Town, State				
	20a. Method of Disposition  1  Burlal 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  RESURRECTION CEMETERY  4/03/20													
	21. Signature of Funefal Service Li	-	1164				FUNER		OME, IN	NC.	POS'	T OFF1	CE BOX	
ian cal ner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert teilure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in deeth)  ISCHEMIC HEART DISEASE  Due to (or as a consequence of):								i c	oproximate niterval Between onset and Death				
I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	Due to (or as	a conseq	juence of):									
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fune					M 2	28d. Describe how Injury occurred Work?  1 Yes 2 No								
Completely filled in by the funer  Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, building, etc. (Specify)							tory, office 28f. Location (Street end Number or Rural Route Number, City or Town, State)						
oletely fill edical	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and my opinion, death occurred at the time, date and place, and manner stated.													
W	29b. Signature end title of certifier	euri st	·D			0883								
	30. Name and address of person w				Print)			COVO	IT DOS			20650		
State	YAHIA M. TAGOUR 31. Dete filed (Month, Day, Year)		0. BOX		25500	JP	UINI L	UUKUL	JI KUAI	), L	EUNA	KDIOWI	I, MD	
State	MAD 9 1	2000 1/2	Lake	LT.	150	2/20	l'ad							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 760. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Margaret Bankert 4a Facility Nemb (If not institution, give street end number) 10.52 PM March 26th 2000 Harman /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County General Hospital Westminster Carroll | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 23, 1931 If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys 1□M 2♥F 69 Yrs. 219-34-4307 Mary I and Usuel Residence of Decedent 10s. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Director Maryland Carroll Westminster 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 15 Pleasant Valley Road 21158 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 unknown Louise Isabelle Bankert 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Pleasant Valley Road, Westminster, MD Allen G. Harman/husband 21158 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State ₩ Burial 2 Cremelion 3 Removal from State St. Mary's UCC Cemetery 3/29 Westminster, MD 4 ☐ Donetion 5 ☐ Other (Specify) Signature of Funeral Service Licanse 22. Neme end Address of Fecility 91 Willis Street Myers Funeral Home Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in deeth) onehour Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State)

physician and s the burial-transit The law requires that the deeth certificate be executed Box 68760. signed by the a of Vital Records, P.O. page 2 certificate Attending Physician: this funeral After Division deeth. within 24 hours after deel To the Funeral Director: filled in by

8 Hospital

\$

**Funeral** 

Director

ir than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examinat

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

death v

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only

State Registrar

edicai

31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

WD

the completed cause of deeth (Item 23a) (Type, Print)

200

MOCH

House officer

MAR 2 9 2000

tiwan

29b. Signeture and little of certifier

38. Name and address of per

Memorial

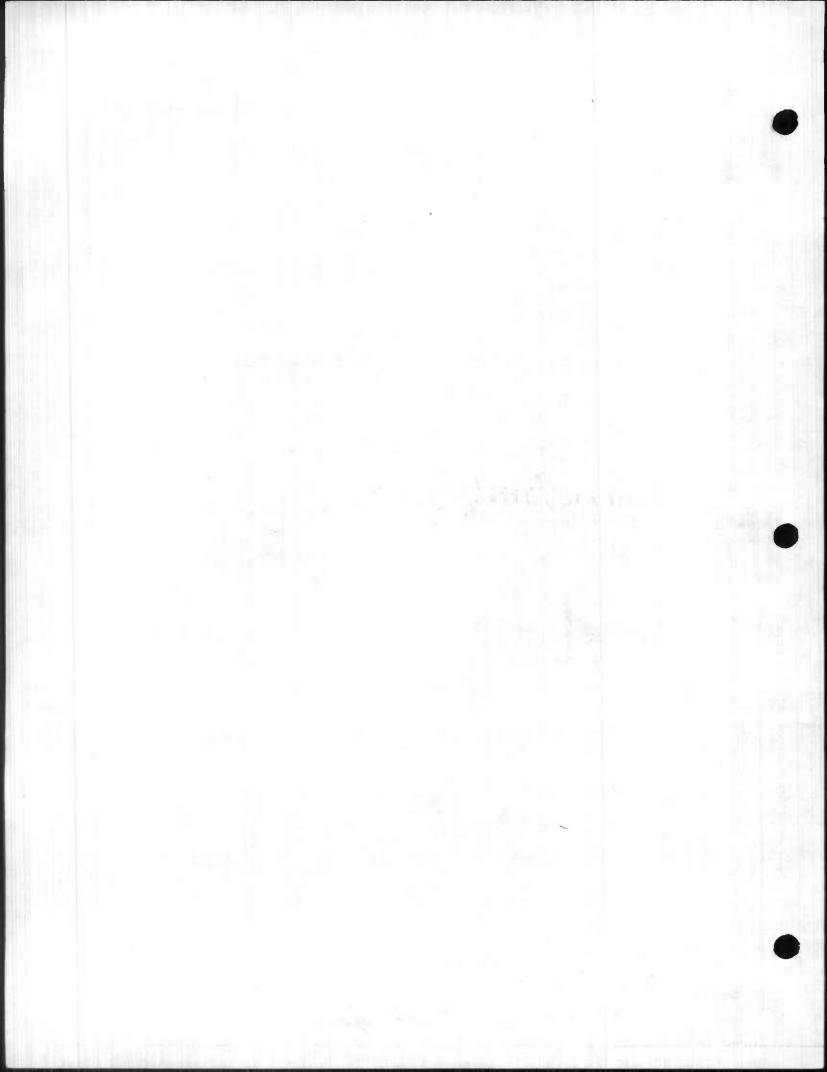
29c. License number

038993

29d. Date signed (Month, Day, Year)

03/26/00

Are Westminster MD 21157



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Lucy Rose 6.05am 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Ridge Sykesville Copper Carro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day Y Aug 28, 7. Age (In yrs. last birthdey) 9. Birthplaca (State or Foreign Year 916 **Funeral** Days Hours 1 ☐ M 2 💢 F 213-28-4563 83 Yrs. Africa **Director** Usuel Rasidence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Baltimore MD Randallstown 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 3711 Stoneybrook Road 23a 21133 U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or itema 23 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates; Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2X No Specify White 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Retail Sales Salesperson 10 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Biagio Salemi Jennie (UNknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rurel Route Number, City or Town, Stata, Zip Code) Mr. Vincent Salemi (Brother) 3711 Stoneybrook Road Randallstown, MD 21133 other 20b. Plece of Disposition (Nema of cametary, cramatory or other plece) 20c. Location - City or Town, Stata 20a. Mathod ol Disposition Department of H Important: If its any Injury or ot poce. Burial 2 Cremetion 3 Removel Irom State Holy Redeemer Cemetery 3/28/2000 Baltimore, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licenses <sup>22</sup> Name and Address of Facility HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 rean 23a. Pent1. Entar the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Intarval Between Onset and Death **Physician** zheimerls Immediate Cause (Finel disease or condition resulting to death) /Medical ears Examiner Due to (or es a consequence ol) Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaase or injury thal initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. | Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown py of Vital Records, 24b. Wera autopsy lindings available prior to completion of cause ol deeth? funeral director, page 2 should Be Completed 24e. Was an autopsy certificate has 1 Yes 2 No 1 ☐ Yea 2 ☐ No or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 45 Nursing Home 5 Residence 6 Othar (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred After Division Injury 1 Matural 5 Pending after death. 1 Yes 2 No investigation 2 Accidant 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) filled in by 4 - Homicida within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. | Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the

State Registrar 31. Dale filed (Month, Day, Year)

29b. Signature and title of certifier

Ernestine Wright

32. Registrer's Signature

COPPERRIDGE

naht

MAR 2 8 2000

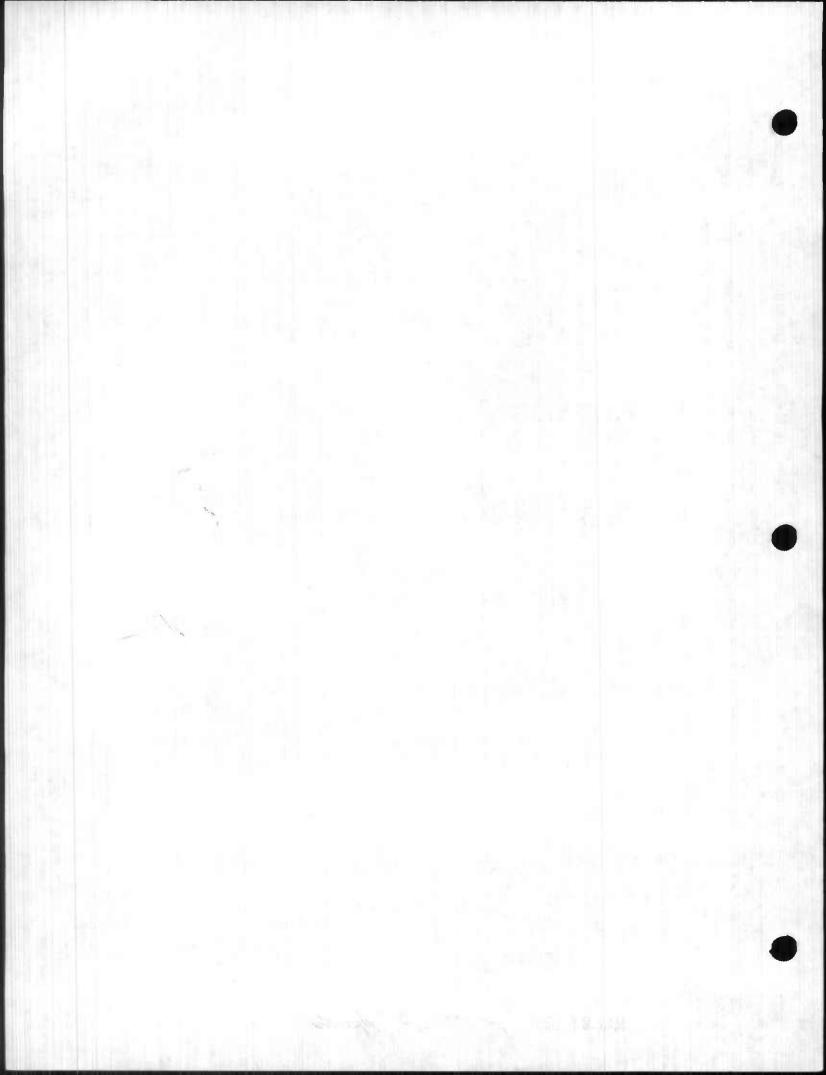
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

710

29c. License number

29d. Dale signed (Month, Dey, Year)

OBRECHT ROAD SYKESVILLE MD 21784



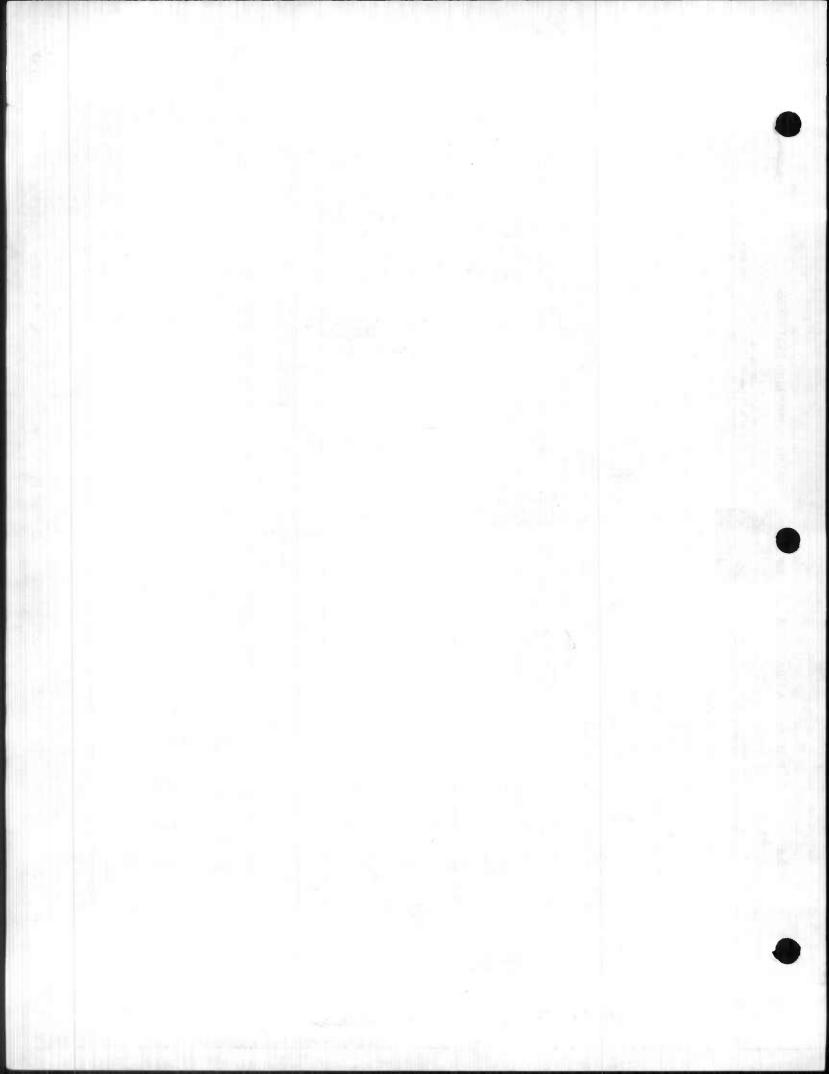
## Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

11762. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Day, **Physician** JAMES OLIVER HUGHES 24 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10 M 2□ F 76 Director 219-16-4753 OCT 9, MARYLAND Usual Residence of Deceden with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show MD CARROLL 1 ☐ Yes 2 No WESTMINSTER Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 538 MARSHALL DRIVE U.S.A. 21157 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

TV☐ Yes 2☐ No If Yes, Give Year or Detes: 14. Rece - American Indian, Black, White, etc. 11 Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after de htel Hygiene. Ind other than "natural", or flam avent, tra moutcal Examination 1 Never Merried 2 Married 21215-0020 WWII 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE py 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COLOR CRAFTSMAN PAINT 11 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mentel marked JAMES OLIVER HUGHES CAROLINE BEDELLA UMBAUGH 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. MYRLE R. HUGHES (WIFE) 538 MARSHALL DRIVE WESTMINSTER, MD 21157 Hem 27 le 20b. Place of Disposition (Name of cemetery, cremetory or other). 20a. Method of Disposition 20c. Location - City or Town, Stete Dete permit. Pages Department of Important: If it any injury or o cemetery, cremetory or other place)
LAKE VIEW MEMORIAL PARK 3/27/2000 SYKESVILLE, MD 1 Daurial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licens 22. Name end Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (P.O. Box 195) Ha Srian of Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one change on each line. Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting In death) CARDIOMYOPATH ISCHEMIC YEARS Examine Due to (or es e consequence of) Examiner CORONARY ATHERO SCLEROTIC lician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician is the buriel Box 68760. Physician/Medical Due to (or as e consequence of) 80 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE Records, b 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed DIABETIC NEPHROPATH) 1 Yes 1 ☐ Yes 2 ☐ No certificate of Vital INSULIN DEPENDENT DIPIBETES MELCITUS Attending Physician: funeral director, 25. Wes case referred to medicat examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 300A Certification: To 1 Inpatient 2 ER/Outpatient this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Atter Division 5 Pending investigation 1 Neturel death. 1 Tyes 2 No 2 Accident within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3/24/00 20 1663 RD WASHINGTONS 7 VINCENT WESTMINSTER, MB SIa 21157 1000 -0 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State WAR 2 8 2000 Registrar " STAN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Gladys Theresa Jennewine March 23,2000 9:05am /Medical 4a. Fecliity Name (If not institution, give street end number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Brooke Grove Nursing Center Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Months 212-03-6908 Director 94 Nov. 24, 1905 Washington D.C. Usuei Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23s or 28s-f show the Medical Expension must be notified at MD Montgomery Director Olney 1 Ves 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 19009 Bloomfield Rd. Funeral 20837 USA 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White py 3 ₩ Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Accounting Clerk Banking/Financial permit. Peges 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 ie marked other any injury or other treumatic event, I 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Albin Ferdinand Wahlstrom Anna Mary McCauley 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Lunow/ Daughter 19009 Bloomfield Rd Olney,MD 20837 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramoval from State Chesapeake Crematory 03/24/00 Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility Rapp Funeral and Cremation Services Jannan 933 Gist Ave Silver Spring, MD 20910 23e. Pert1. Ent. I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or rasplratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death **Physician** Congestive Hear failure /Medical Immediete Ceuse (Finel diseesa or condition rasulting in death) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In death) Lest pue Due to (or es e consequence of): Physician/Medical the Due to (or as a consequenca of): 80 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. be detached 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed hes page 2 certificate 1 ☐ Yes 2 ☐ No funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Dete of Injury (Month, Dey Year) 27. Mender of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 No after death 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 124 hours 6 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the vithin 2 29b. Signatura and title of certifig 29c. Licanse number ture and tiple of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year)

March 23<sup>rd</sup> 2000

and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MUL GILOTRA M.D. 12016 GEORGIA Avenue Wheaten 20902

State

The law requires that the death certificete be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospitai

death.

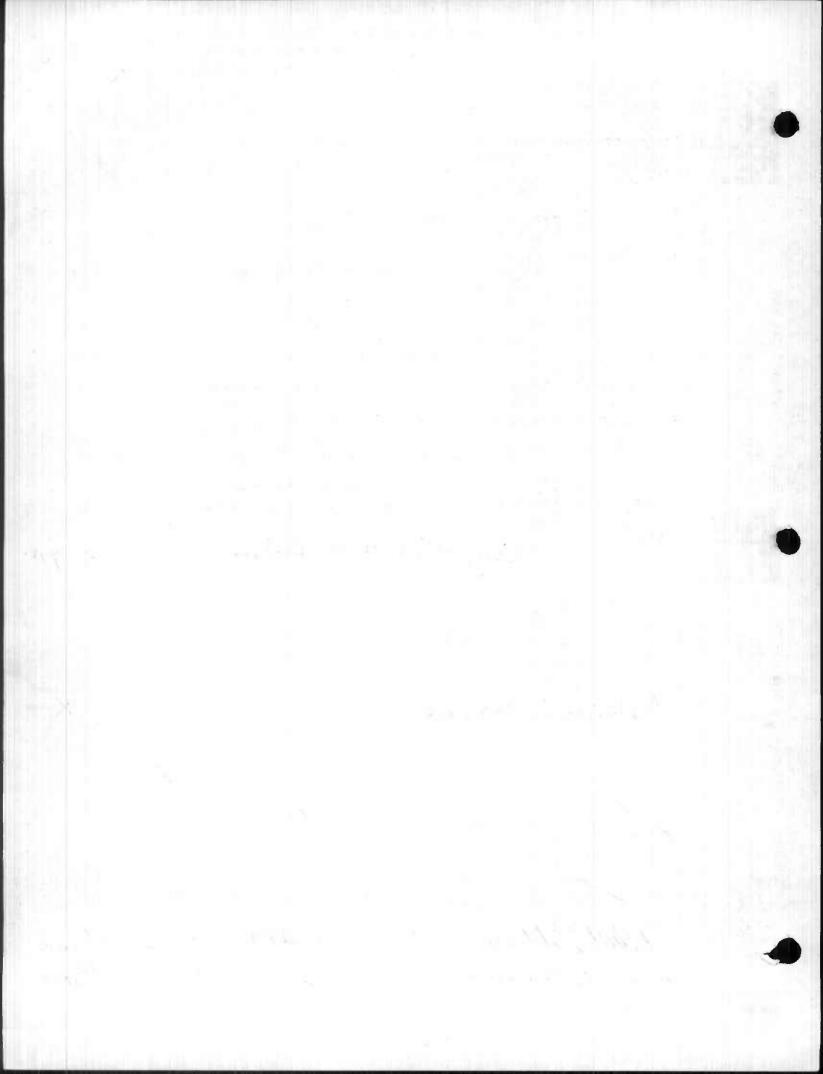
deeth with the Meryland

filed within 72 hours efter

21215-0020

Baltimore, Maryland

31. Dete filed (Month, Dey, Year) MAR 2 8 2000 32. Registrer's Signeture Freva



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 2000 8, DAVIES JOHNSON MARCH 12:15 A.M. MARIE /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SILVER SPRING HOLY CROSS HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 15, 1903 5. Social Security Number Birthplace (State or Foreign Country)
 Liberia **Funeral** Deys 1□ M 2 1 F 97 219-94-8513 Jan. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Md. Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 East West Highway 20910 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - Americen Indien, Black, White, etc. filed within 72 hours effer. Hygiene. ither than "naturel", or ite 1 Never Married 2 Married naturel', or 1 ☐ Yes 2 🛛 No Specify: g Specify: 3 ₩idowed 4 Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Boutique Owner Retail Peges 1 and 2 should be filed nent of Health end Mental Hygi-int: If Item 27 Is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Oliver Bright Nancy Mai Ashford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11957 Old Columbia Pike Silver Spring, Md. 20904 Archibald Johnson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 3 + 13 - 00Washington, D.C. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Capitol Mortuary, Inc. a 1425 Maryland Ave., NE Wash., DC 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical INANITION MONTHS Examiner Due to (or as a consequence of): Examiner YEARS STROKE (MULTIPLE) ettending physician end for use as the burial-transit the death certificete be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 ☐ Yee 2 ☐ No 3 ☐ Probably Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physiclan: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospitai: 1 ⅓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No funeral 27 Manner of Doeth 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours efter death. To the Funeral Director: After t' completely filled in by the funera 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

5530 Wisconsin Ave. Ste. 930 Chevy Chase, Md.

D39456

29d. Date signed (Month, Day, Year)

March 13, 2000

State Registrar

Baltimore, Maryland, 21215-0020

Box 68760.

P.O.

Division of Vital Records.

APR 11 CCCCC A A

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

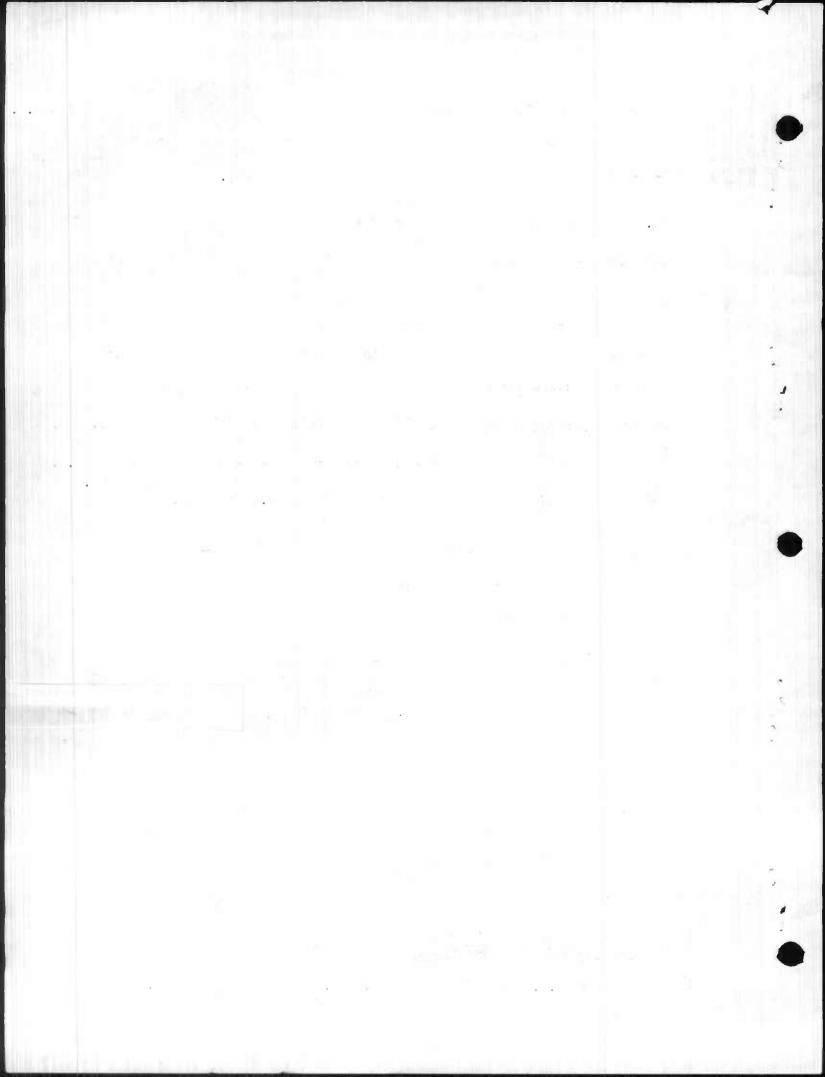
Dene

**DHMH 16 Rev 6/95** 

(Check only one)

29b. Signature and title of certifier

Lila McConnell, M.D. 31. Date filed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Physician 1845 MARCH Everett Lee , 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Harford Fallston Fallston General Hospital If Under 24 Hrs. 5. Social Security Number 8. Data of Birth July 16, 1940 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (Stata or Foreign Chilo Funeral Days Months Hours 1⊠M 2□ F 59 268-34-3257 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Harford Edgewood Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 iner must be 510 Pintail Court United States 21040 Funeral Departit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Merits! Hygiens. Important: if Isen 27 is marked other than "natural", or Isens 23 any folloy or other traumatic event, the Madical Examinar must more. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. Armed Forces 1 NYes 2 No If Yes, Give 1956-57 Year or Datas: 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White þ 3 ☑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) Be Everett Jewell Leona Mae Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 5334 M. Mazan / daughter Baltimore, MD 21237 King Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-28-00 Chesapeake Crematory, Inc. Beltsville, MD 22. Name and Address of Facility CAFA Stephen D. Lohmann, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Towson, MD 21286 Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner geeding Dusteral Ulcerc Examiner physician and s the burlat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): for use as signed by the a d be detached f Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Toles 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 has certificata SSIVE 1 ☐ Yas 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2540 Impatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Matural 5 Pending 1 Yas 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

Records, P.O. Box 68760. of Vital or Attending Physician: Division death.

VERGT

the Maryland

Baltimore, Maryland 21215-0020

24 hours after deatl Puneral Director: filled in by To the Hosp within 24 ho To the Fune completely fi +

29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

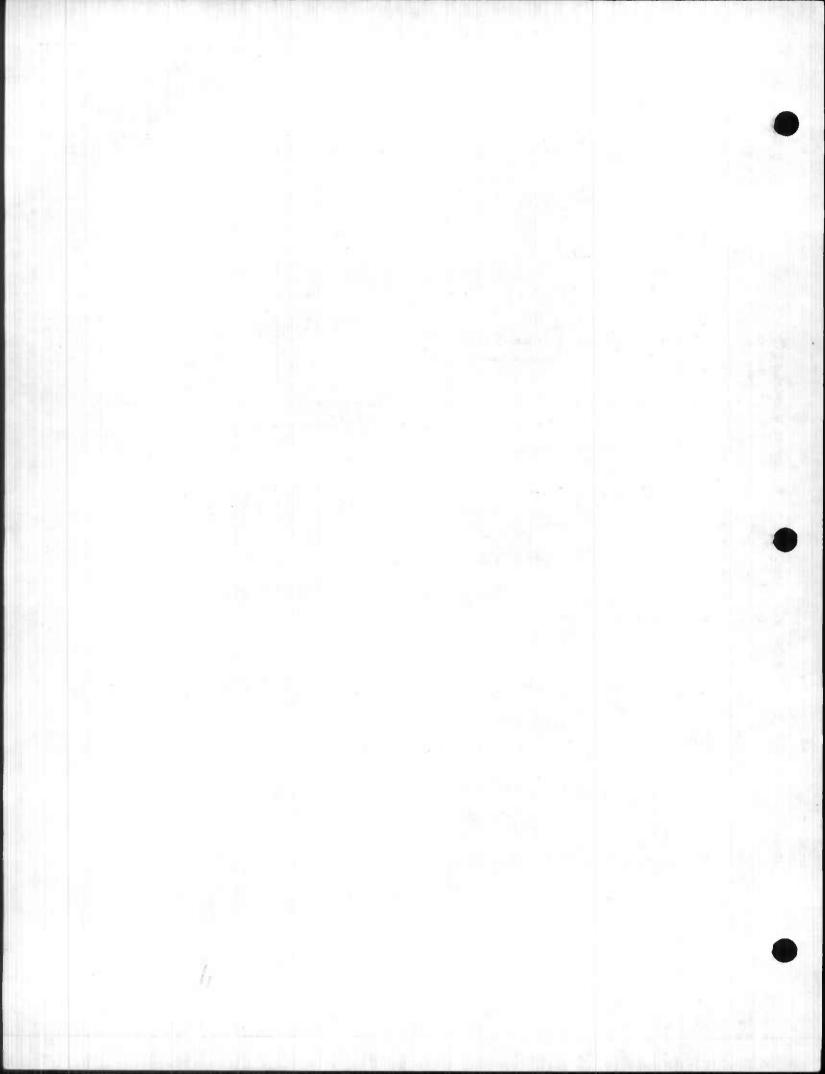
and address of person

eted cause of death (Item 23a) (Type, Print)

moss 1. 31. Data filed (Month, Day, Year) MAR 2 8 32. Registrar's Signetura 2000

State Registrar

Medical

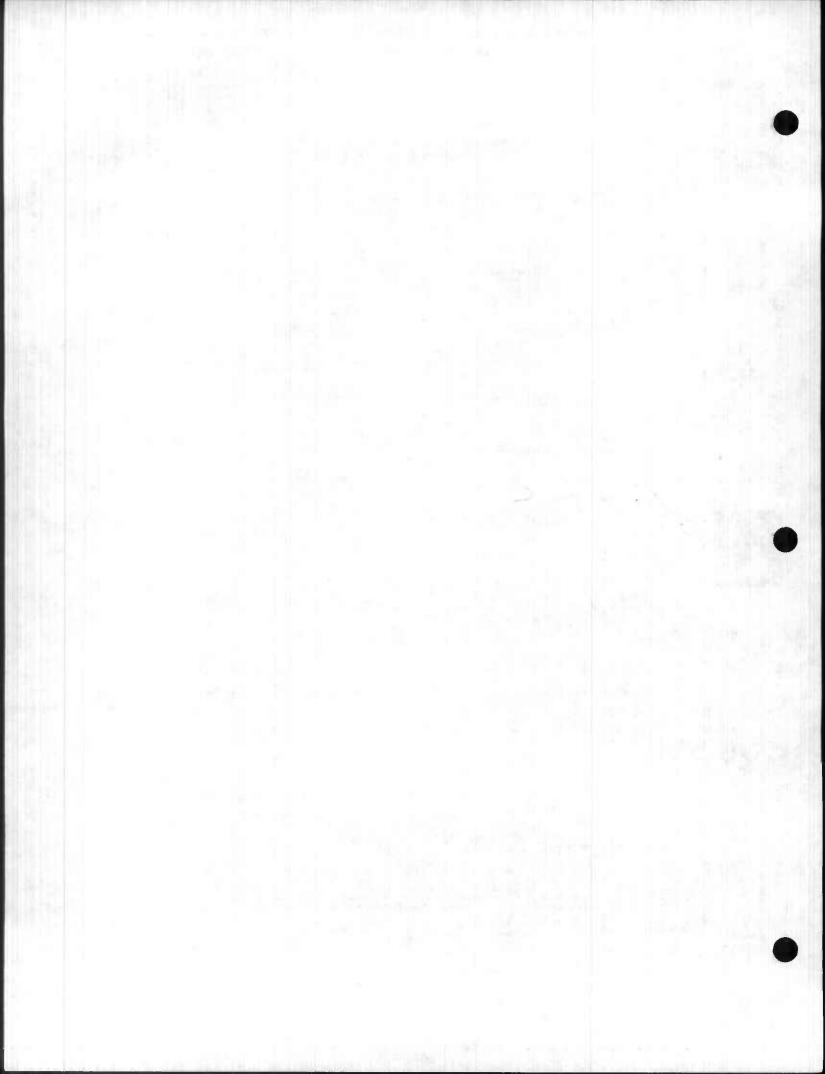


## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 1 1 766

						Cei	rtificat	e of	Death			Re	g. No.			
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Genevieve Johnson  4a Facility Name (If not Institution, give street and number)									Month Day Year		e of Death				
	Genevieve	2		Jo	hnson								_		2	:25 AM
	4a Facility Name (If r	not Institution, giv	e street and n	um <i>ber)</i>					4b. City, To	or L	ocation of	Deeth	4c. Count	y of Deeth		
	Potomac V	Valley N	ursing	and	Wellr	ness	Cente	r	Ro	ckvi	11e		M	ontgo	mery	
	5. Sociel Security Nur		Sex	7. Ag	e (in yrs. lest	birthdey)	tf Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date (Mon	of Birth	Voorl	9. Birth	place (Ste	ate or Foreign
	577-05-350	8	1□M 2ÅF		81	Yrs.	Months	Days	Hours	TVIII I.	May	12,	1918	Nort	h Ca	rolina
	Usual Residence of D															
	10a. State	10b. County			10c. City, T	own or Lo	cation									le City Limits
Director	Maryland	Montgom	ery			Beth	esda								10	Yes 2 No
	10e. Street and Numb	per					10f. Zip	Code				10	g. Citizen of	What Cou	niry?	
-	7500 Sha	dvwood	Road				20	817				1	Inited	Stat	.00	
	11. Marital Sfetus		12. Was De	cedent	Ever in U.S.	13.1			lispante Or	igin? (Sc	ecify Yes		United States		n.	
I	1 ☐ Never Married	1 2□ Marriad	Armed F	Forces?			f Yes, spec	ify Cub	an, Mexica	n, Puerto	pecify Yes or No- o Rican, etc.) 14. Rece - Amer Bleck, White					
	3 ☑ Widowed 4		If Yes, G	Sive	10		1 ☐ Yes	2⊠ No	Specify:		Specify: White				4+-	
ŀ				Dates.		Sa Dance	dante Hau	I Occur	nation				Ch Vind of E	White		
l	(Specify	<ol><li>Decedent's E only highest gr</li></ol>	ede completed	1)		(Give	dent's Usua kind of wo DO NOT us	rk done	during mos	it of work	16b. Kind of Bustne				loustry	
	Elementary/Second	dary (0-12)	College	(1-4or 5	5+)		hier	101110	0,		Food					
		Inch Adiabate Cons	1								o /Final I	Catalla 0.				
ļ	17. Father's Name (F. George E.		•			18. Mother's Name (F								me)		
19 Bes 20 la mark of the state	dedige 1.		Hessie E. Roberts						LLS							
	19a. Informant's Nam			Address (Street end Number or Rurel Route No												
	Barbara R. Johnson/Daughter 7500 Shadywood Road, Bethesda, Maryland									and 2	.0817					
	20a. Method of Dispo		U.L.		20b. Place	e of Dispo	sition (Ner	ne of ther ple	ce)	1	March	29 2	Oc. Location	- City or To	own, State	е
	1 ☐ Burial 2 ☒ 4 ☐ Donation 5			n State					m, Inc		200		etheso	la. Ma	arv1:	and
	21. Signature of Fund			_	1				-							
	10	11	1				557 W	isco	nsin	Ave	rune	ral	Home/	Bethe Ch	sda-	Inc.
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	23a. Part 1. Enter the shock, or heaft	failure. List only	plicetions thet one cause on	each lin	the death. [ ne.	Do not ent	er the mod	e of dyir	ng, such es	cardiac	or respire	tory erre	sf,			Between
															Onset e	end Death
	Immediate Cause (Fi	nal	Pr	eum	onia											
	resulting in death)				Due to (or as	a consec	quence of):							1		
ı			Ch	ron	ic Ren	al Fa	ailur	6								
	Sequentially list cond	litions	b		Due to (or as											
ı	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate	De	men												
	cause. Enter Underly Cause (Disease or In that initiated events		C		Due to (or as	a consen	uence of):									
ı	resulting in death) La	st			200 10 (0. 20											
			d													
											1					
	Part II. Other significa	ant conditions o	contributing to	death b	ut not resultin	ig in the u	nderlying c	euse giv	en in Part	i.	230					use of death?
												1 🗆 Ye	s 2□ No	3 Pro	bably	4 🖾 Unknown
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											24a	Was an perform	autopsy led?	6/	vailable pi	
١														of	ompletion f death?	or ceuse
												1 ☐ Ye	s 2 No	1	□Yes	2 No
ŀ	25. Was case referred	d to medical					- 11		26 Place	e of Dear	th (Check	only one	1	1		
	examiner? 1 ☐ Yes 2 ② No		Hospitat:	] Inpatie	at all ED	/Outpatier	1 3□ DC	Oth	oer:				nce 6 🗆 Ot	has (Cassi	76.73	
ŀ	27. Manner of Death		28a. Date			b. Time of				urally ric			w injury occu		197	
	1 2 Natural	5 Pending investigatio	(Mo	nth, Day	Year)	Injury	M	8c. Inju	rk? ∣Yes 2 🗆	No						
	2 ☐ Accident 3 ☐ Suictde	6 ☐ Could not b	e Dec Blac	no of Ini	un. At home	form at					28f Loca	tion /Str	eat and Num	her or Bur	ral Poute	Number
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work?								Der Or Hur	ar noute i	redition,						
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one) and manner steted.																
29b. Signeture and fittle of certifier 29c. L							29c. License number 29d. Date signed (Month, Dey, Year)				ar)					
March 28.								28, 2	000							
1	30. Name and addres	s of person who	completed cau	use of d	eath (Item 23	a) (Type	Print)									
	Thomas V.							Dri	ive.	1207	. Roc	kvi	11e M	arvla	ind 2	0852
t	31. Date filed (Month,		1 1		ar's Signature			213		. 207	, 100	- T- A T-	LLC, II	итута	.114 Z	0052
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DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARTHA MARCH 25, 2000 MAE JONES 10:30PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COLLINGTON EPISCOPAL LIFE CARE MITCHELLVILLE PRINCE GEORGE'S | Months | Days | Hours | Min. | July 10, 1911 | MISSOURI 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 88 232 78 9322 Yrs. Director **Usual Residence of Decedent** 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director MD PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1045 LOTTSFORD ROAD 20721 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hyglena. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flam 27 is marked oth any fujury or other traumatic avam pages. PAUL A. CALVERT EULA HART 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN BERGBAUER (DAUGHTER) 71 KILBRIDE DRIVE PINEHURST, NC 28374 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom Stete GATE OF HEAVEN 3-29-00 4 ☐ Donation\_5 ☐ Other (Specify) SILVER SPRING, MD 22. Name and Address of Fecilia INES-RINALDI 11800 NEW HAMPSHIRE 21-Signature of Funeral Service Lice AVENUE SILVER SPRING, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Daath Physician Immediate Cause (Finel disease or condition resulting in death) ardiopulmonary Prest

Due to (or as e consequence of):

Therescleratic Heart Disease /Medical Examiner 720 years herosclerotic Examiner physician and the burlat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Dementia Records, à 24b. Were eutopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2000 1 Yes 2 300 Division of Vital Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 

Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 70 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 100 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1∏Yes 2□No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, Ierm, street, lactory, office building, etc. (Specify) 4 Homicide 1StCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 27, 2000 D37934 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green way Center Drive Greenbett 10 20220 7500 Stephanie fogliof D 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

MAR 28 2000

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Year Month **Physician** 23, MARCH MARGARET J. JOPPY 2000 1105 /Medical 4b City Town or Location of Death 4s Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Suburban Hospital Bethesda MONTGOMERY | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Sept. 2, 1953 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Yrs 46 Director Maryland 214-60-5572 Usual Rasidance of Dacedan the Maryland 10c. City, Town or Location 10a. Steta 10b. County 10d. Insida City Limits MD Montgomery No Yas 2 No Director Gaithersburg 288-7 10g. Citizan of What Country? 10a. Street and Number 10f. Zip Coda à 107 N. Summit Avenue 20877 mathe U.S.A. 23a Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 20000 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 72 hours after Nevar Married 2 Married 21215-0020 'natural', or 1 ☐ Yas 2 ☐ No Specify: If Yes, Giva Yeer or Detes: Specify: Black À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Hygiene. Hygiene. other then "n Elamentary/Secondary (0-12) Collega (1-4or 5+) 12th Homemaker Home Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any fillury or other traumatic event 9059. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Sumama) Be Rhodie Joppy Margaret Wade 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) Janice M. Moten (Niece) 10102 Blue Tee Terr, Montg. Vlg, MD 20886 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata Lincoln Park Cem. 3/31/00 Rockville, MD 4 □ Donation 5 □ Othar (Specify) 21. Signe ura of Funaral Sarvice Ligensaa 22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. 20850 nou ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart faligire. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical 15 days Pneumonia Examiner Due to (or es e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Diseasa or Injury Dua to (or as a consequence of): certificate be Physician/Medical that initiated evants resulting in death) Last Due to (or es e consequence of): 980 P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 | Yes 2 | No 3 | Probably € Unknown Chronic Renal Failure Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Insulin Dependent page 1 Yas 2 XNo 1 ☐ Yas 2 ☐ No Diabetes Mellitus Vital Be 25. Wes case refarred to medical axaminar? 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 Yas 2 No Certification: To Inpatiant 2 ER/Outpatient 3 DOA to this 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Natural 5 Panding invastigation 1 Yas 2 No Director: A 2 Accident 6 Could not be determined

Division

MARCAR

or Attending death. hours aftar To the Hospital within 24 hours a To the Funeral C completely filled

29e. Certifier (Check only one)

3 Suicide

AmiT

4 Homicida

Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the ceuse(s) and mannar as stated.

| Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daeth occurred at the time, data end place, and dua to the cause(s) and mannar stated. 29b. Signature end title of certifiar

29c. License number

29d. Data signed (Month, Day, Year)

D37891

Mar. 23, 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

RAJVansti MI

20852 121 Congressional Ln, #409, Rockville, MD

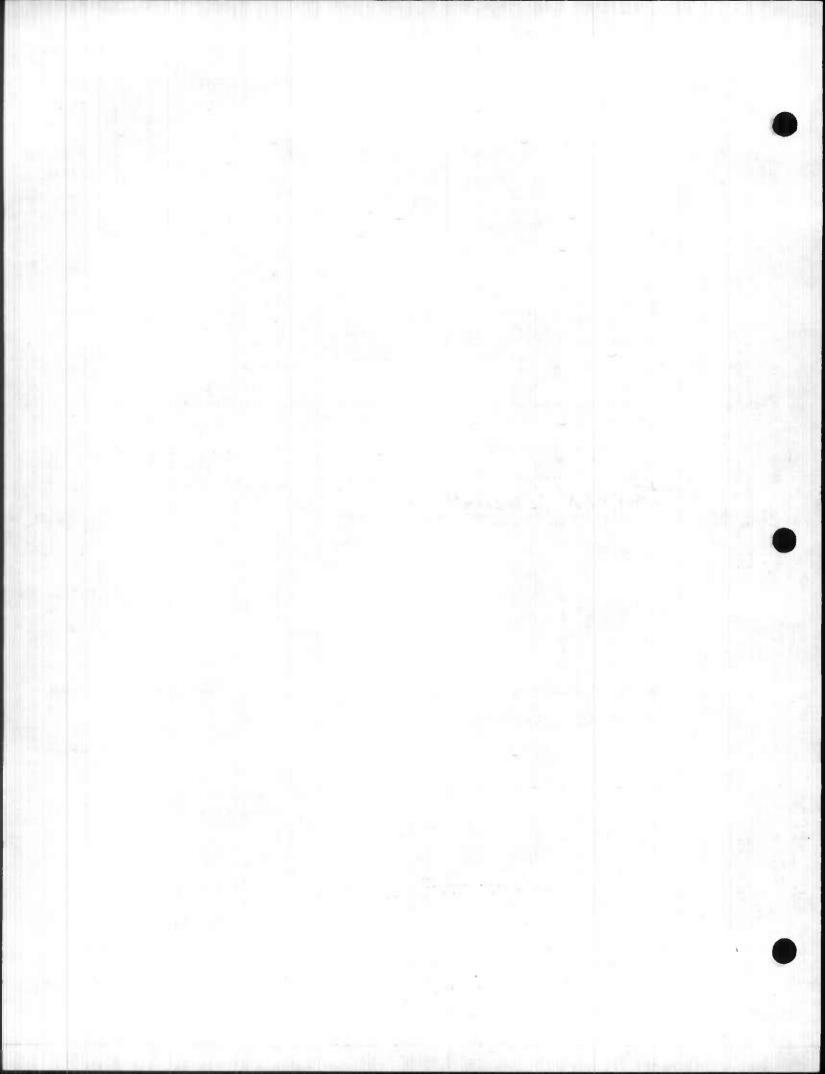
State Registrar

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31. Data filad (Month, Day, Year) MAR 29

32. Registrar's Signature

28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

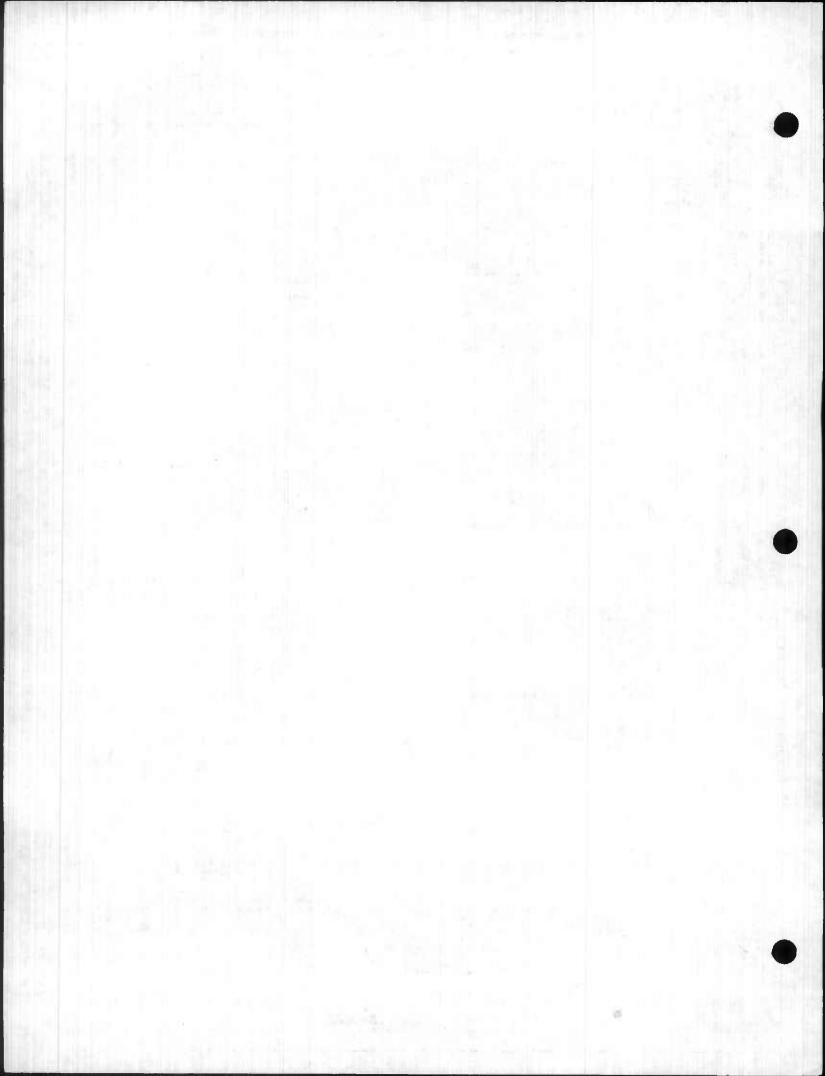


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State of Maryland / Department of Health and Mental Hygiene

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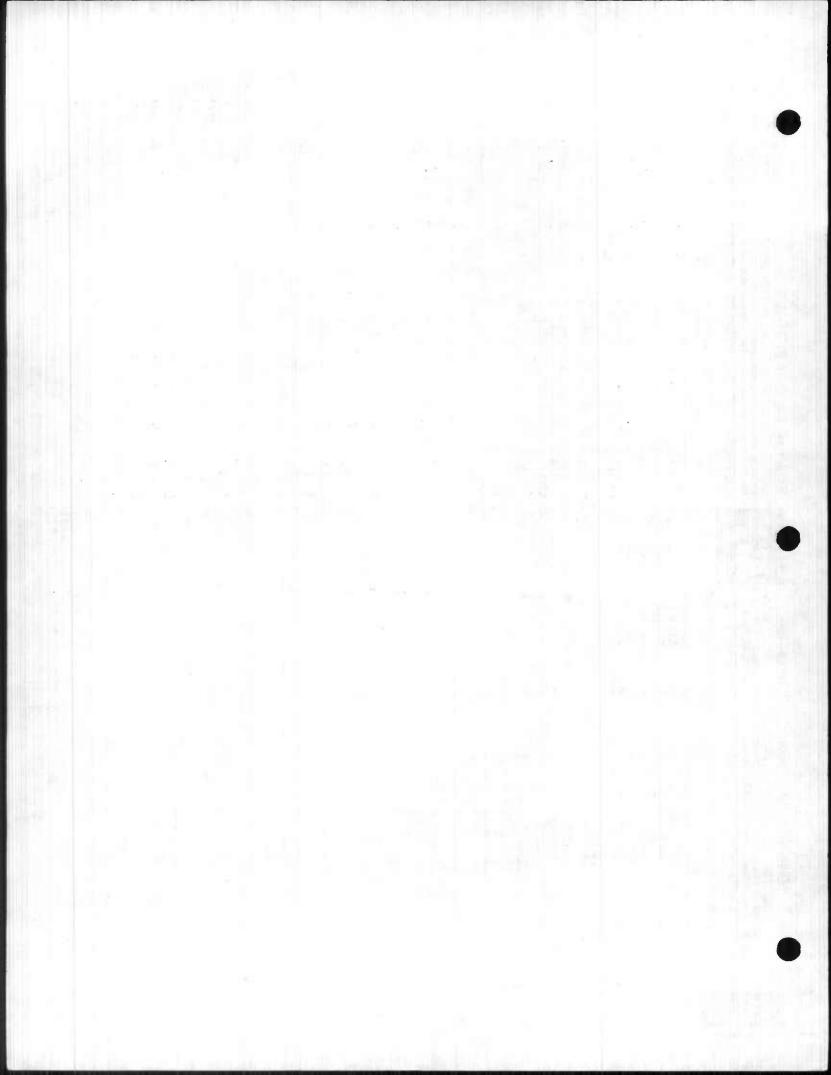
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	Neme (First, Middle, L.	est)	- 50		181			2. Date of Dec	eth	Van	3. Time of Death		
an Hesook	Kim Kang						1	Month March 2	Day 4. 200		5:40am		
VUI .		ve street end number)				4b. City, Tov		ation of Death	-		J. roun		
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216-92-	8086	1□M 2⊠F	71	Yrs. Month	s Deys	Hours	Min.	Nov. 2,	1928	W 145			
Usuel Resident			7.1					10 0 1 2 9	1720	ROI	ca		
10e. Stete	10b. County		10c. City, Town	or Location						1	10d. Inside City Lim		
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10e. Street and		inc 2 y	ROCKVI		Zip Code				10g. Citizen of	Whet Cour	ntry?		
12630 1	eirs Mill	Pond			20853				70300				
12630 V		12. Wes Decedent B	Ever in U.S.			lispento Orig	gin? (Spec			ce - Americ	can Indian,		
	Married 28 Married	Armed Forces?	lo	If Yes, s	pecify Cub	en, Mexican	, Puerto F	cify Yes or No- Rican, etc.)	r, City or Town, State, Zip Code) Rockville, MD 20853				
	ed 4 Divorced	If Yes, Give Yeer or Detes:		1 ☐ Yes	2 No	Specify:			Speci	Kor	ean		
	15. Decedent's E		16a.	Decedent's Us	sual Occur	pation			16b. Kind of I				
	Specify only highest gr	rade completed)		(Give kind of life. DO NOT	work done	during most	t of workin	ng					
Elementery/S	Secondary (0-12)	College (1-4or 5		ousewif	- 0				Over	Home			
17. Father's Na	me (First, Middle, Las		- 11	OUSCWII		18. Mothe	r's Name	(First, Middle,	-	2000 5:40am c. County of Deeth  Montgomery 9. Birthplace (State or Foreign Country) 1028 Korea  10d. Inside City Limits 1 Yes 25 No  Sitizen of Whet Country? ea  14. Race - American Indian, Bleck, White, etc.  Specify: Korean  Kind of Business/Industry  Own Home on Surneme)  For Town, State, Zip Code) kville, MD 20853 Location - City or Town, State ney, Maryland Home  Approximate Interval Between Onset end Deeth  Sycass  20 years  20 years			
HAK M	. KTM					SHT	N CH	s Name (First, Middle, Maiden Sumeme)  CHANG					
17. Father's Name (First, Middle, Last)  HAK M. KIM  SHIN CHA  19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rural I									City of Town	o Cinto 7in	Codel		
20e. Method of	on C. Kang	(Husband)		Disposition (A		III KC	oad #	Dete Dete					
	2 Cremetion 3	Removel from Stele	cemeter	y, cremetory o	r other ple	ce)	1	Dete	ZOC. LOCATION	- City Of To	JWn, Stete		
4 ☐ Doneti	on 5 Other (Speci	ify)	Norbec	k Memo							land		
21. Signeture	of Funerel Servica Lice	nsee						ol Fune	ral Ho	me			
16	cetes. C.	Day				er Pa							
23a. Part1. En	ter the disease, or con	nplications that caused	the death. Do r	not enter the m	ode of dyir	ng, such as	cardiac or	r respiretory ar	rest,		Approximate		
Sequentially lie if any, leading cause. Enter to Ceuse (Diseas thritted ear resulting in dear resulting in dear	st conditions, to immediate Juderlying e or Injury vents ith) Last	c. Die	Due to (or es e o	28 M	elle	Of the	s.	the co	48		20 ya		
Pert II. Other st		d. ///	cerp	ut.	100	NI C	~~	11/01			1		
Pert II. Other si	gnificant conditions	contributing to death bu	at not resulting in	the underlying	g cause giv	ven in Pert I.		23b. Dld 1	obacco uss c	ontributs t	o the cause of de		
								10	788 2 No	3 ☐ Pro	bably 4 Unki		
4 - 5								24a. Was perfo	an autopsy med?	av	fere autopsy findir vaileble prior to empletion of cause deeth?		
4								10	res 2 No	11	Yes 2 No		
25. Was rece t	referred to medical					26 Place	of Death				74,		
examiner?	2 No	Hospitel:	at 20500	tnotice: 20	DOA Ott			(Check only o		ther /C	(h)		
		1 Inpatie		tpetient 3	DOA	4 Nu		ne 5 Resident			197/		
1 Naturel	5 Pending	28a. Dete of Injur (Month, Day	Year) i	njury M	28c. Inju	rk? Yes 2 ☐ I			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
2 Accide 3 Suicide 4 Homic	6 ☐ Could not I	De Disse of fair	ury - At home, fe :. (Specify)				2	28f. Location (: City or Tox		nber or Run	el Route Number,		
27. Manner of Death 1 Naturel 2   Accident 3   Suicide 4   Homicide  29a. Certifier (Check only one)  28a. Dete of Injury (Month, Day Year) 28b. Time of Injury M   28c. Injury at Work? 1   Yes 2   No 28e. Plece of finjury - At home, ferm, street, fectory, offica									ece, end due to the ceuse(s) and manner as stated.				
								ed (Month	Day Voer				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								Lou. Date Sign	חווטמן ואטוונה,	Jay, roar/			
Bym my Doo21033 March							narcy	124	1,200				
30. Name end address of person who completed cause of death (Hern 23a) (Type, Print)  13000 Georgia Aue, Silverspring. May 12096							1.						
13	000 6	reorgie	2 Au	10, -	SIK	ler:	501	rmg.	Many	dad	2090		
31. Dete filed (	Month, Day, Year)	32 Registre	er's Signeture	1	,			0	1				
	MAD 2 8 2	Aller Aller	species 1	4 1	an W.								



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 11770

			C	ertifica	te of	Death		3	Reg. No.				
	1. Decedent's Nama (First, Middla, Li	est)						2. Data of Dec	ath		3. Time of De	ath	
Physician	Mok King						Month	28, 200	Year	7:25	ΔΜ		
/Medical	4a Facility Name (If not institution, gir	ve street and number)				4b. City. To	wn, or Lo	cation of Death	_	12 - 2 - 2 - 2	1.23	MI	
Examiner													
	Forest Glen Nur		(In um last hirths	four If Linde	r 1 Year			pring 8. Date of Birt		gome			
Funeral		12M 2□F	(In yrs. last birthd	Months		Hours	Min.	(Month, Day	y, Year)	9. Birtho	place (Stata or Fo	oreign	
Director	156-36-7997 Usuat Residence of Decedent		101 <sup>Yrs</sup>					Jan 4,	1899	Chir	na		
D	10a. State 10b. County		10c. City, Town o	r Location						1	10d. Inside City L	Imite	
aryle at a state of a											1 Yes 2		
to the start of	Maryland Montge	omery	Silver								-		
or 28a-4 s be notified Director	10e. Street and Number			10t. Zi	Code				10g. Citizen of 1	What Coun	ntry?		
deeth with the Maryland me 23e or 23e-f show Linual be notified at neral Director	1703 Donald Pl			2	0902				USA				
	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U,S.	<ol><li>Was Dece If Yes, spe</li></ol>	dent of h	tispanic Ori an, Mexicar	gin? (Spo	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.					
within 72 hours aher she than "ratural", or his be Medical Examina ompleted by Fu	1 ☐ Never Married 2 ☒ Married	1 Yes 2 No		1□ Yes		Specify:	127		Specity:				
Ent.	3 Widowed 4 Divorced	Year or Dates:			-34	opcomy.			Specing	7-	Asian		
Tan Matu	15. Decedent's E (Specify only highest gr		16a. De	ecedent's Usu Rive kind of wo	at Occup	ation	t of work	ina	16b. Kind of B	usiness/Inc	dustry		
ed within 72 ho yglene. her then "natur it, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+	- Iii	e. DO NOT	se retire	d)	. UT HUTK						
Hygien ther the ent. the		5		ofesso	r			Education					
18 28 2	17. Father's Name (First, Middle, Last	)				18. Mothe	er's Name	(First, Middle,	t, Middle, Maiden Sumame)				
marked umatic av	Che Chung			Wong King Chuer					n				
THE P	19a. Informant's Name/Retationship	Type, Print)	19b. M	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						Code)			
Department of Health a Important: If New 27 is any Injury or other tra	Perry K. Mok/Son 20a, Method of Disposition	1	20b. Place of Di	isposition (Na	Vista Dr, Rockville, MD 20853 sition (Name of Date 20c. Location - City or Town, Stat						own, State		
0 6 8 8	1 N Burial 2 ☐ Cremation 3 E		cemetery,	crematory or	other pla								
111	4 Donetion 5 Other (Speci		Gate of										
10 40	21. Signature of Funeral Service Lice	nsee	2017	22. Name a	nd Addre	ss of Facili	Hin	es-Rina	ldi Fun	eral	Home		
5 2 3	I alan 1 1	Donnell		11800	New	Hamps	hire	Ave, S	ilver S	pring	ring, MD 2090		
	23a. Part1. Enter the disease, or con shock, or heart tailure. List only	plications that caused the	he death. Do not	enter the mo	de of dyi	ng, such as	cardiac (	or respiratory ar	rest,		Approximete Interval Between		
ysician	SHOCK, OF Healt tailule: List Only	one cause on each line									Onset and Dea		
ledical	Immediate Cause (Final		Pneu	monia						1	2 week	cs	
miner	disease or condition resulting in death)	a								1			
i .		U	ue to (or as a cor							1			
physicien end s the buriel-transit edical Examin		b		le Dem		a					l year	;	
rial-transit Examiner	Sequentially list conditions, if any, leading to immediate	D	ua to (or as a con	isequence of)	:					1			
buring as	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							35-11	1			
edical	resulting in death) Last	De	ue to (or as a con	sequence of):									
2		d											
igned by the attending place be detached for use as to be detached for use as to by Physician/Mec													
betached for us Physician/	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying	cause gi	ven in Part I		23b. Did 1	obacco use co	intribute to	o the cause of d	Jeath?	
Ph Ph								10	Yes 2 No	3 Pro	bably 4 Uni	known	
è à													
should								24a. Was perfo	an autopsy med?	V8	ere autopsy tind railable prior to		
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omp omp								101	res 2 kNo	11	Yes 2 No	,	
0	25. Was case referred to medical					of Dise	D N		41				
I director, pege 2	axaminer?	Hospital:			_ Ot	nor-		h (Check only o		10			
E T	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Dete of Injury	2 ER/Outpe		UA	4LAIN!		me 5 Residente 1			7/)	-	
y the fune	1 Natural 5 ☐ Pending	(Month, Day	Year) Inju	ry M	28c. Inju Wo	rk? Yes 2 🗆		200. 0000120	ion injury occus				
Director: After I in by the fune ertification	2 Accident investigation					169 2					10 . 11 . 1		
- A	27. Manner of Death  1 Natural 2 Accident 3 Suicida 4 Homicide  28a. Dete of Injury (Month, Day Year)  28b. Tima of Injury M  28b. Tima of Injury M  28b. Place of Injury At home, farm, street, factory, building, etc. (Specify)						t, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
2 0 0									own, State)				
une Cal	29a. Certifier 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and consider the time, date and place the time, date and the time, dat												
To the Funeral Director: After the completaly filled in by the funeral Medical Certification:													
To To To	29b. Signature and title of certifier			29c. License number 29d. Date signed (Month, Day, Year)				111					
t	MM MD.						D52457 March 28, 2000						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mo-Ping Chow 9001 Shady Grove Ct, Gaithersburg, MD 20877												
State	31. Date filed (Month, Day, Yeàr)	32. Registrar											
State Registrar			w B	do	all								
	110 111 0 11 -												



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Kina Patricia March 02:00 28,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hopkins Hospital Baltimore Johns 7. Age (In yrs. last birthday) | If Under 1 Year | Months | Days H Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dev. Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 213-46-7613 Director July 6, 1946 Washington D.C Usuel Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No must be notified Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a Seneca 1005 Drive 21703 A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give / Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Marital Stetus Black, Whita, atc. 72 hours after 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No "natural", or Specify: by Specify: 3 □ Widowed 4 □ Divorced White i filed within 72 ho i Hygiene. other then \*nature went, the Medical E Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary Board of Education 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is manked other any Injury or other traumatic event Be Clarence Sterling Tucker 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. King / Sonuse Romald 1005 Seneca Drive Frederick MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta Date 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Amtomic GIA Foundation March 28,00 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomic Ciff Foundation 13949 Baltimore Hyrnize Larel MD 20707 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat end Death **Physician** 24 hours /Medical Immediata Cause (Final disease or condition resulting in death) Examines Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es a consequence of) Box 68760. Physician/Medicai Due to (or es e consequence of) 987 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 € Unknown Be Completed by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en autopsy performed? page 2 should certificate has 1 Yes 28 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: funeral director, 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Malneatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide 29e. Certifier 125 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the ceuse(s) end manner steted.

State

10

31. Date tiled (Month, Day, Year) MAR 3 0 2000 Registrar

Nelsor

29b. Signatura and title of certified

600 32. Registrar's Signeture Sepera

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

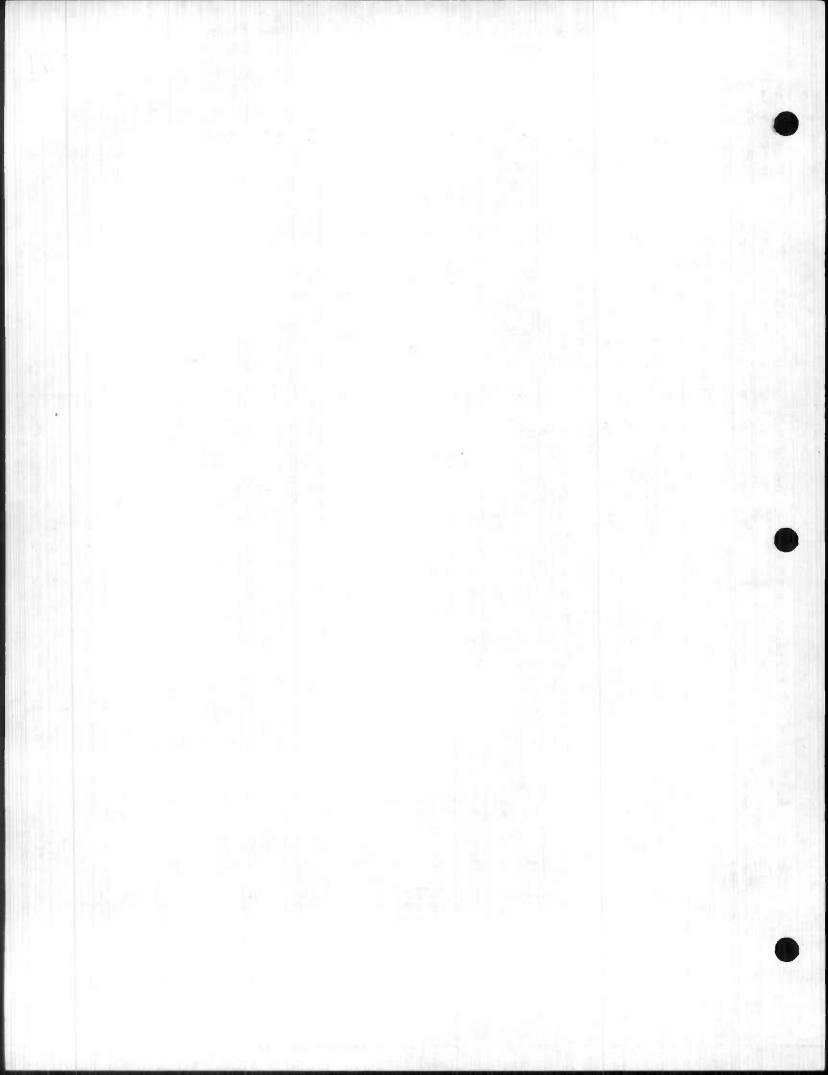
Wolfe St. Baltimore, MD

29c. License number

RES-OUTC

29d. Date signed (Month, Dey, Year)

0



oion				Centitio	ate of	Death		Reg. No.	00	11/12			
	1. Decedent's Nama (First, Middla, L	ast)	110	£ 10			2. Date of De Month	Day	Year	3. Time of Death			
cian dical	Wilma Rose King						March	26, 200	0	2:00 PM			
iner	4a Facility Nama (If not institution, g	iva street and number	7)			4b. City, Town, or Lo							
	217 West Montgo	mery Avenu	e			Rockville		Montg	omery				
al or	5. Social Security Number 6. 579-30-8615	Sex 7. A 1 M 2 M F	ga (In yrs. last bi 72	Yrs. If U	ndar 1 Yaar Ihs Days		8. Data of Bir (Month, Da Feb. 15	th ly. Year) , 1928	Country	ce (State or Foreign y) ylvania			
	Usual Rasidence of Decedent  10a. State 10b. County		10c. City, Tow	m or Languign					100	Landa Ohatimia			
-	10a. State 10b. County  Maryland Montgon	0.777	Rockv						100	I. Inside City Limits  1 ☑ Yes 2 ☐ No			
Director		iely	ROCKV		7. 0.1			10. 0%	10-10-1				
	10e. Street and Number			100	. Zip Code			10g. Citizen of V					
Pra	217 West Montgom				0850	Historia Odala? (Ca	anife Van as Na	United	State a · American				
by Funeral	11. Marital Status  1 ☐ Nevar Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Yaar or Dates	I No			Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Blac	ck, Whita, et	o.			
8	15. Decedent's (			Decedent's	Usual Occu	pation		16b. Kind of Bu					
Completed	(Specify only highast g	rada completed)		(Give kind o life. DO NO	f work done IT use retire	pation during most of work ed)	ing						
E	Elementery/Secondary (0-12)	College (1-4or	5+)	elf Em				Artis	t				
BeC	17. Father's Name (First, Middle, Las	t)				18. Mother's Name (First, Middla, Maiden							
OB	George McAtee					Margaret	Gates						
1 1	19e. Informent's Neme/Relationship	(Type, Print)	198	b. Mailing Add	Iress (Stree	t and Number or Run	State, Zip C	ode)					
	Vance A. King/ S	on	2	17 Wes	t Mon	tgomery Av	enue.	Rockvill	e, MD	20850			
	20e. Method of Disposition		20b. Placa C	of Disposition	(Nama of		arch 28,	20c. Location -					
	1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec		8					Bethesda	a. Mar	vland			
	21. Signature of Funeral Licenses												
	1 the 1 th	A MOV	200		ville,	Inc. 30	0 West	Montgom	ery Av				
	23a. Farth Enter the disease, or co-	mplications that cause y one cause on each	0689 ed lhe daalh. Do	not anier the	Rock	ville, Mar	ryland or respiratory a	20850-28 rrast.		oproximate			
, 8	enotal or neuriteilure. List onl	y one cause on each	line.							nterval Between Onset and Death			
i	Immediate Cause (Final	Armi	SC (Man)	CAGI	SID MZ	roum (	DIYARA		i				
	disease or condition resulting in death)	a. Indan	Angarioscumatic Cardinarycu um 1						1				
9			Due to (or as a	consequence	01):				1				
Examiner	Convention for the state of the	b	Due to (or as a	00000000000	of):				j j				
EXB	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or as a	SOUBPAREL SO	orj.				- 1				
Cal	Ceuse (Disease or injury that initiated events	c	Dua lo for se s	consequence	of):								
	resulting in death) Last		Dua IO (Or as a	Dua Io (or as a consequence of):									
for use as the bunk													
		0											
sician	Part II. Other significant conditions	contributing to death	but not resulting	in the underly	ing cause o	iven in Part I.	23b. Did	tobacco use co	ntribute to 1	he cause of death?			
hysician	Part II. Other significant conditions	contributing to death	but not resulting	in the underlyi	ing cause gi	iven in Part I.		tobacco uee co	ntribute to 1				
by Physician/Med	Part II. Other significant conditions	contributing to death	but not resulting	in the underlyi	ing cause gi	iven in Part I.		\_/					
by	Part II. Other significant conditions	contributing to death	but not resulting	in the underlyi	ing cause gi	iven in Part I.	1 🗆	\_/	3 Probe	bly 4 Unknown a autopsy findings able prior to pletion of cause			
by	Part II. Other significant conditions	contributing to death	but not resulting	in the underlyi	ing cause gi	iven in Part I.	1 🗆	Yes 2 No	3 Probe	bly 4 Unknown			
Completed by		contributing to death	but not resulting	in the underlyi	ing cause gi	iven in Part I.	1 - 24a. Was	Yes 2 No	3 Probe	e autopsy findings able prior to pletion of cause sath?			
Be Completed by	25. Was case referred to medical examiner?	Hospital:		in the underlyi		26. Place of Deal	24a. Was perfo	Yes 2000	3 Proba	e autopsy findings able prior to pletion of cause sath?			
To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpal	ient 2□ ER/O	utpatient 3D	] DOA	26. Place of Deal ther: 4 ☐ Nursing Ho	24a. Was performed to the Check only one 5 Mess	Yes 2 No  Yes 2 No  One)	3 Probe  24b. Wer avail com of de  1 □	e autopsy findings able prior to pletion of cause sath?			
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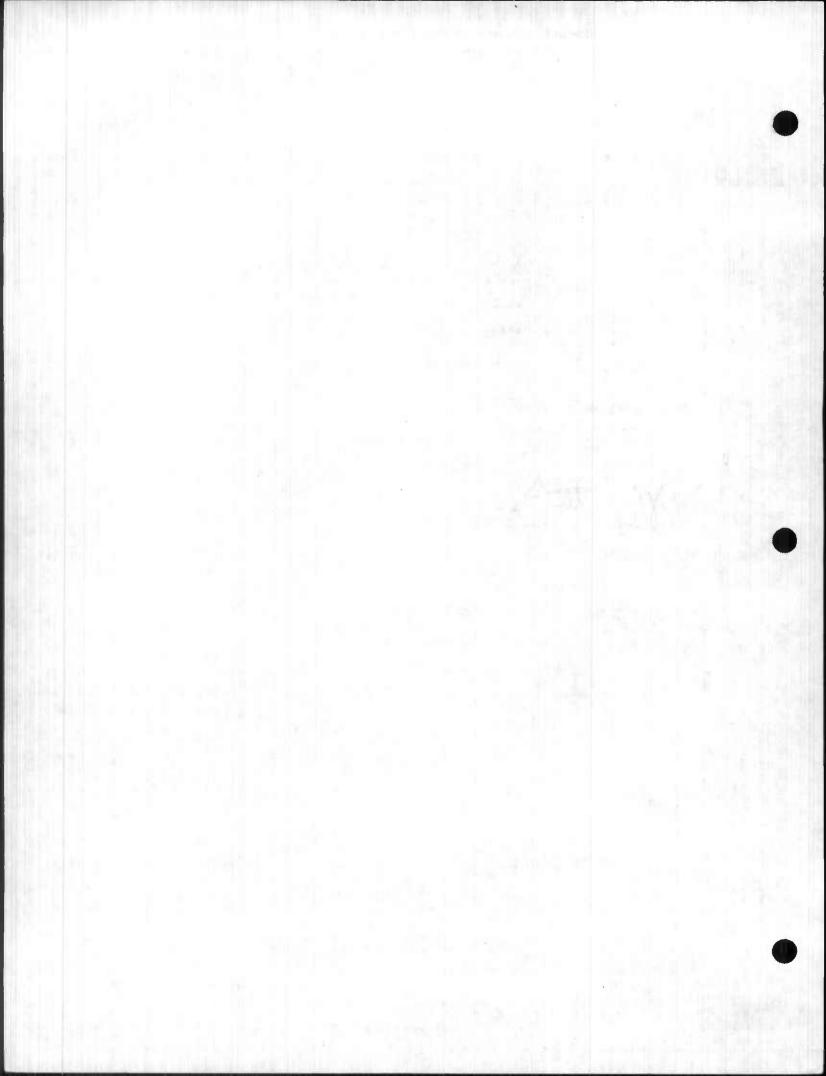
State Registrar 31. Data filed (Month, Dey, Year)
MAR 2 9 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

B. Sparks

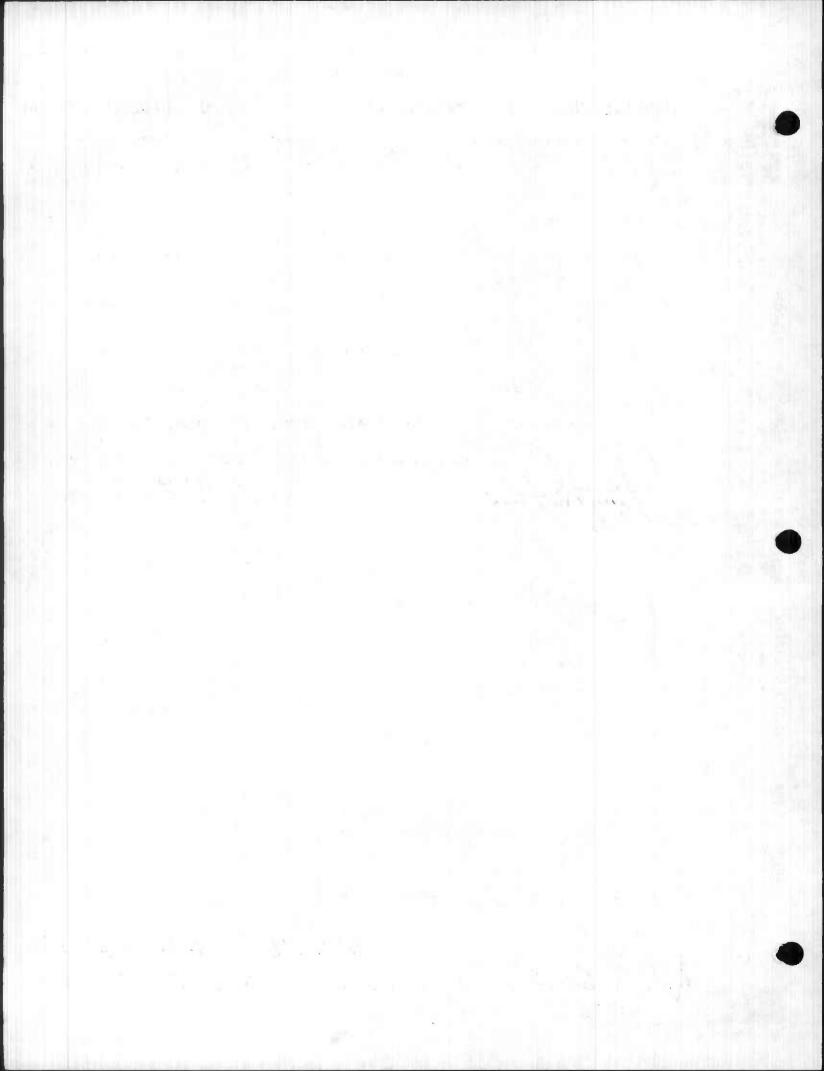
Carl I. Margolis, M.D. 11125 Rockville Pike, #211, Rockville, Maryland 20852-314%



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate of	Death	Reg.	No.		
Physician	_	. Decedent's Nama (First, Middla, La	st)	11	701			2. Date of Death	Day	Yaer 3. Tim th	
/Medical	ш.	Marquerite	J	HOS	stan	10		11 Jarch	2420	000 9:53	
Examiner		a. Facility Name (If not institution, giv					4b. City, Town, or I		4c. County o	of Death	
	-	Frederick Health				Willed and Manager	Frederic		Frede		
unerai rector		. Social Sacurity Number 6. S 374-36-3669	Sax 7. Ag	a (In yrs. las	Yrs.	If Undar 1 Yaa Months Days		(Month, Day, Ya	1907	Birthplaca (Stata or Foral Country)     Illinois	
ž ==		Oe. Stata 10b. County		10c. City,	Town or Loca	ation				10d. Insida City Limi	
f show		Maryland Montgom	20.0017	Co	aithers	ahuwa				1 □ Yes 2 □ N	
e de		Maryland Montgom	lery	Ge	irther	10f. Zip Coda		100	Citizan of Wh		
2 0		19621 Brassie Pla					879				
era	-	1. Marital Status	12. Was Decedant	Evar in U.S.	13 W				ited S	- American Indian,	
Tatural, or items 23a or 28a-i shor portal Era-ring must be notified at leted by Funeral Director		1 Nevar Married 2 Married 3 Wildowed 4 Divorced	Armad Forces? 1 ☐ Yes 2 ☒ If Yas, Giva Year or Dates:			Yas, specify Cul ☐ Yas 2 X No	Hispanic Origin? (S ban, Maxican, Puart Specify:	Ricen, atc.)		, Whita, atc. White	
Completed		15. Decedent's Ed (Specify only highast gra	ducetion		16a. Deceda	nt's Usual Occu	pation	16b	. Kind of Bus	lnass/Industry	
	-	Elementery/Secondary (0-12)	Collage (1-4or 5	i+)	lifa. Do	O NOT usa retin	e during most of wor ed)	king			
E NO		12			Sec	cretary			Gover	nment	
or other traumatic event, the M	1	7. Father's Nama (First, Middla, Last)					18. Mother's Nan	na (First, Middla, Maid	dan Sumama,	)	
To		Adolph	Johnson				Elle	n Sun	neson		
5		9a. Informant's Name/Ralationship (	Type, Print)		19b. Mailing	Addrass (Stree	at and Number or Ru	ral Route Number, Cit	ity or Town, S	itata, Zip Coda)	
4		Joanne Rock, dau	ghter		19621	Brassi	e Place,	Gaithersbu	irg, MI	20879	
<b>f</b>	2	0a. Mathod of Disposition		20b. Plac	e of Disposit	tion (Nama of	aca)		. Location - C	City or Town, State	
5	1	1 Burian 2 □ Cramation 3 □ 4 □ Denation 5 □ Other (Spacify				Memori		Mar 31 2000 La	ntana.	Florida	
any injury	1	1. Signature of Fanagal Sarvica Ligen		‡ aliii		Nama and Addr	ar rare		-		
any injury or other tr		Jace 7.  23a. Part1. Entar tha discussa, or companion, shock, or haart fail r. List only	Thei		10	E. Dee:	r park Dr	DeVol Fun ., Gaither	sburg,		
edical miner	r	mmedieta Causa (Final lisaasa or condition esulting in daath)	a. Ceru	Dua to (or a	s a conseque		head	Call		Syears	
inel-transit Examiner		dequantially list conditions, any, leading to immadiata ause. Entar Underlying ausa (Disaasa or Injury nat Initiated events	b. ———	Dua to (or a	s a consequa	ance of):					
es the buriel-fransit Medical Examir	ti	rausa (Disaasa or Injury nat Initiated events asulting In daath) Last	C	Dua to (or a	s a conseque	ence of):					
			d								
ysic	P	art II. Other significant conditions of	ontributing to death be	ut not resulti	ng in the und	erlying causa gi	ivan in Part I.	23b. Did tobac	co uae conti	ribute to the causa of dest	
by Physician							<u> </u>	1 ☐ Yes	2₽No 3	3 ☐ Probably 4 ☐ Unkno	
2 should pieted								24a. Was en au performed		24b. Were autopsy findings available prior to completion of ceusa of daath?	
Com								1 ☐ Yes	20 No	1 ☐ Yas 2 ☐ No	
0 ()		5. Wes case refarred to medical axaminar?					28. Place of Dee	th (Check only one)			
3e C		1 Yas 2 No	Hospital: 1 ☐ Inpatia	nt 2 EF	VOutpatient	3□ DOA Ot	har: Nursing H	oma 5 🗆 Rasidance	6 □Othar	(Specify)	
director.		ILI TAS SEINO	1 □ Inpatiant 2 □ ER/Outpatient 3 □ DOA □ M□ Nursing H  28a. Data of Injury (Month, Day Year)   28b. Tima of Injury   28c. Injury at Work?					Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)  28d. Dascribe how injury occurred			
To Be	2	7. Manner of Death 1. Neturel 5 Panding 2. Accident Invastigation					1103 2 1140				
In by the funaral director, rtiflcation: To Be	2	7. Manner of Death 1 Neturel 5 Panding		ury - At home :. (Spacify)	e, farm, strea			28f. Location (Straat City or Town, St	t and Number tata)	or Rural Routa Number,	
In by the funaral director, srtification: To Be		7. Manner of Death 1 Neturel 5 Panding Invastigation 3 Suicida 6 Could not be datarmined  9a. Cartifiar 1 Certifying Physics	28a. Place of Injubuliding, atc	f my knowle	odge, daath o	t, factory, office	ima, data and place	28f. Location (Straat City or Town, St and dua to tha causa red at tha tima, data e	tata) a(s) and manr	nar as stated.	
In by the funaral director, rtiflcation: To Be	2	7. Manner of Death 1 Neturel 2 Aocident 3 Suicida 4 Homicida  9a. Cartiflar (Check only 2 Medical Exam	28a. Place of Injubuliding, atc	f my knowle	odge, daath o	t, factory, office	ima, data and place, opinion, deeth occui	City or Town, St and dua to tha causa red at tha tima, data s	a(s) and manr end place, en	nar as stated.	
in by the funaral director.	2	7. Manner of Death 1 Neturel 2 Aocident 3 Suicida 4 Homicida  9a. Cartiflar (Check only one)  7. Manner of Death 5 Panding Invastigation 6 Could not be datarmined	28a. Place of Injubuliding, atc	f my knowle	odge, daath o	eccurred at the tistigation, in my	ima, data and place, opinion, deeth occur se number	City or Town, St and dua to tha causa red at tha tima, data s	a(s) and manr end place, en	nar as stated. Indidua to tha causa(s)	
completely filled In by the funeral director.  Medical Certification: To Be	2	7. Manner of Death 1 Neturel 2 Aocident 3 Suicida 4 Homicida  9a. Cartiflar (Check only one)  1 Certifying Phyone)  2 Medical Examples  3 Signature and title of certiler	28a. Place of Injubuliding, ato building, ato yelclan: To the bast of and mannar sta	f my knowle axamination tad.	odge, daath o n and/or invas	ccurred at the tistigation, in my	ima, data and place, opinion, deeth occui	City or Town, St and dua to tha causa red at tha tima, data s	a(s) and manr end place, en	nar as stated. Indidua to tha causa(s)	
petaly filled in by the funaral director.	2	7. Manner of Death 1 Neturel 2 Aocident 3 Suicida 4 Homicida  9a. Cartiflar (Check only one)  1 Certifying Phyone)  2 Medical Examples  3 Signature and title of certiler	28a. Place of Injubuliding, atc	f my knowle axamination tad.	odge, daath o n and/or invas	ccurred at the tistigation, in my	ima, data and place, opinion, deeth occur se number	City or Town, St and dua to tha causa red at tha tima, data s	a(s) and manr end place, en	nar as stated. Indidua to tha causa(s)	

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Letitia Josephine Kwiatkowski 30 2000 7:30 AM March 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro Prince Georges 12922 Molly Berry Road Hours Min. March 19, If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1□ M 2XF Months Days Yrs. Pennsylvania 72 175-22-1650 Usual Rasidanca of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No MD Upper Marlboro Prince Georges 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 12922 Molly Berry 20772 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas; Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian. Biack, White, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a, Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Dacadant's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Coilega (1-4or 5+) Home Homemaker 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Sybil J. Rhodes Gerald Francis McAuliffe 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20608 17420 Aquasco Farm Rd. Aquasco, MD. Patricia Grant/Daughter 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State Resurrection Cemetery4/3/00 Clinton, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) of Funaral Sarvice Licensae 22. Nama and Addrass of Facility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. Approximata Intarval Batwean Onsat and Daath Immediate Cause (Final disaasa or condition rasulting in daath) LUNG Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or injury that Initiated events rasulting in daath) Last Due to (or as a consequence of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 □Othar (Specify) 1 Yes 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding 1 ☐ Yas 2 ☐ No 2 Accident invastigation

**Examiner** physician and the burief-transit that the death certificeta be exec Division of Vital Records, P.O. Box 68760, 88 USB signed by the peed pege 2 has cartificata Hospital or Attending Physician: funeral director. After this aftar death.

Physician/Medicai by Completed Certification: To

edicai

Examiner To the Hospital or Attar within 24 hours aftar der To the Funeral Directo completaly filled in by th

**Physician** 

\* /Medical

Examiner

Director

Funeral

py

Completed

2

**Funeral** 

Director

th and Mentel Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. If them 27 is marked other than "natural", or fler any injury or other traumetic evant. the

**Physician** 

/Medical

Baltimore,

the Marylend

with

death

29a. Certifier (Check only one)

3 Suicida

4 Homicida

6 Could not be determined

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Va 20646

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

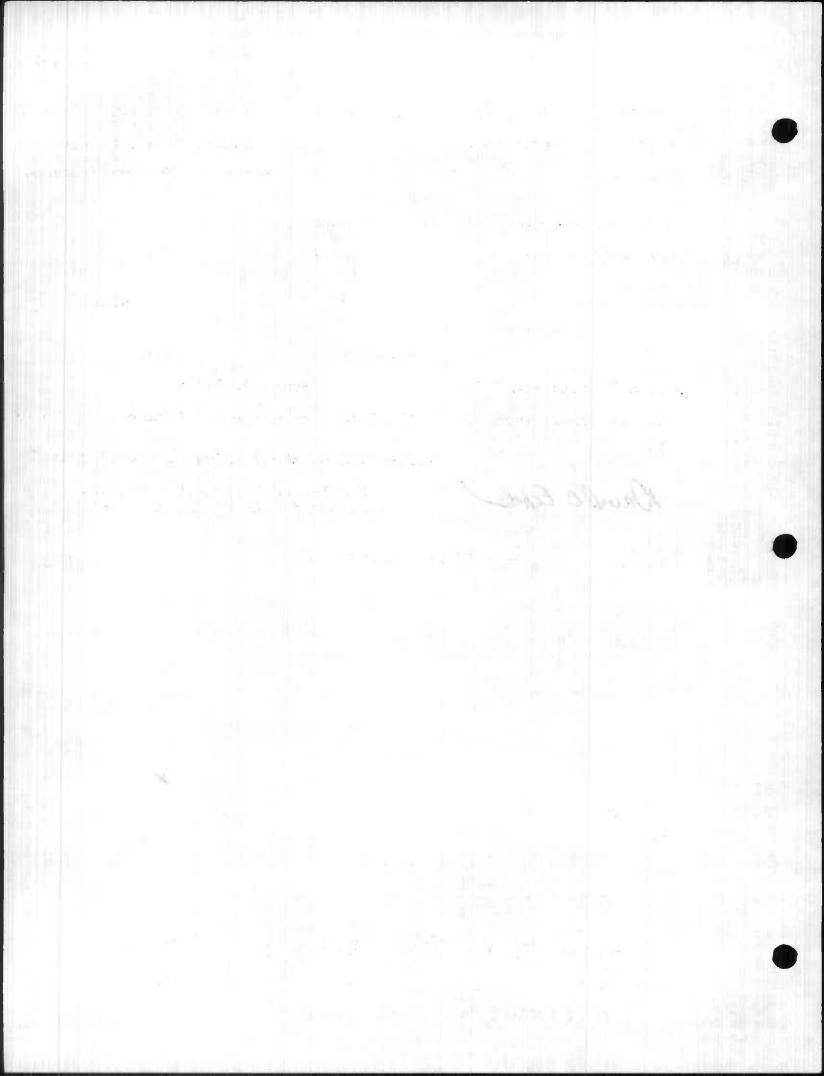
Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number

00

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

19

State Registrar 31. Data filad (Month, Day, Year) 32. Registrar's Signatura APR 0 3 2000



State of Maryland / Department of Health and Mental Hygiene

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	1	-	1	U

					Ce	rtificate	of	Death			Reg. No.		1 1	113
Physic /Medi		Decedent's Name (First, Middle, I  Steph	en Lo		(raush	ofer				2. Date of Do Month March	Dey 25, 2000	Year	3. T	ime of Death )PM
Exami	ner	4a. Facility Nama (If not institution, g 6419 Oakland Mills Roa		m <i>ber)</i>				4b. City, Tov Sykesville	е	ation of Deat	th 4c. Cou	onty of Death Carrol		
Funeral Director		5. Social Security Number 215 - 56 - 8159  Usual Residence of Decedent	Sax 12 M 2□ F	7. Age (In yrs. le:	st birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	B. Date of Bi lov 27,19	rth Year)	9. Birth Con	nplace (5 untry) Maryla	Steta or Foreig and
Maryland f show	ō	10a. State 10b. County	Carroll	10c. City,	Town or Lo	cation kesville								side City Limit
th with the Maryla 23a or 28a-f shou	I Director	Maryland  10e. Street and Number  6419 Oakland Mills Roa				10f. Zip C	oda		2178	10g. Citizen of W			f What Country? U.S.A.	
ter dea Items	by Funeral	11. Marital Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 ☑ Yes	edant Ever in U,S. rces? 2 No 4-27 /e ates: 9-8-7	- 41	Was Daceder If Yes, specify		dispanic Orig an, Mexican, Specify:			No- 14. Race - American Ind Black, White, etc. Specify: White			ian,
within ene.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rede completed) College (1		(Give	dent's Usual ( kind of work DO NOT use Service	done retire	during most d)	of working	9	16b. Kind of Business Heating and Ai			itioning
should be filed and Mental Hygi marked other umetic event, I	o Be C	17. Father's Neme (First, Middle, Les Emil	it)	Krausho	ofer			18. Mother	8. Mother's Name (First, Middle, Maiden Sumeme)  Lorraine Roberts					
nd 2 should lith and Men 27 is marke traumetic	=	19a. Informant's Name/Relationship	19a. Informant's Name/Relationship (Type, Print)  Linda L. Kraushofer/ Wife						r or Rural	Route Numb	per, City or Too			
S 1 and 1 Heal		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Ramoval from 5	20b. Ple	netery, crei	sition (Neme metory or other	of		1	Date	ville, Maryl 20c. Locatio		Town, Sta	
permit. Page Department of Important: If any injury or		4 ☐ Donation 5 ☐ Other (Spec 21. Signatura of Funeral Servica Lice	-	Car		oll Cremation, Inc. 3/29/2000 Trainpstead Wall 22. Name and Addleffrefrefrefrefrefrefrefrefrefrefrefrefr						ment (	Co.	
Physician /Medical		234 Part Eribi the disease, of control of the contr	nplications that cay one cause on ea				of dyin	ng, such es d	cardiac or				Appro Intervi Onsat	eximate al Between t and Daath
Examiner	e	disaase or condition resulting in death)	a	Non 5 m	is a consec	quence of):	10	er he	-)			l l	8 1	no ath
ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or a	is a consec	juence of):					,	-		
ding p	Medical	Cause (Disease or Injury that initiated events rasulting in death) Lest	d	Dua to (or a	s a conseq	uenca of):						1		
daath daath e atter	Physician	Part II. Other significant conditions	contributing to de	eath but not resulti	ing in the u	nderlying cau	se giv	ven in Part I.		23b. Did	tobacco use	contribute	to the c	nuae of death
d by	by Phy	Type I	O Gety	melloris						120	Yes 2□Ne	o 3□Pro	obably	4 Unknow
aw requir	Completed b	,									en eutopsy ormed?	a	vailable	n of causa
Physician: The interpretation of the director, page	Be	25. Was case referred to medical examiner?	Hospitai:				Ott		of Death	1 Check only	Yes 22 No	1	□Yes	2 No
E de la	Certification: To	1 Yas 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date o (Monti		R/Outpatier  Bb. Time of  Injury		. Inju	4 LI NUI	28		dence 6 00 how injury occ		ify)	
al or Attending s aftar death. I Director: After	Sertific	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicide determine	28a. Place	of Injury - At hom ng, etc. (Specify)	e, farm, str	eet, factory, o	office		26		Street end Nu wn, Stete)	m <i>ber</i> o <i>r R</i> ui	ral Route	Number,
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	edical (	29e. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exe	hyalcian: To the miner: On the ba and menn	best of my knowle asis of examination per stated.	edge, death n end/or inv	occurred at the control of the contr	the tir	ne, date and plnion, deeth	plece, en	d due to the l at the time,	cause(s) end dete end plac	menner es a, end due	stated. to the ca	iuse(s)
To the within 2 To the comple	Me	29b. Signature and title of cartifier	99-			29c. L		e number 45570			29d. Date sig	ned (Month	, Dey, Y	ear)
		30. Neme end address of person who Glenn Herman 1380 F	completed cause rogress Wa	e of death (Item 2 y Eldersbur	<sup>3е)</sup> (Туре,	Print) 21784			-9					

32. Registrar's Signature

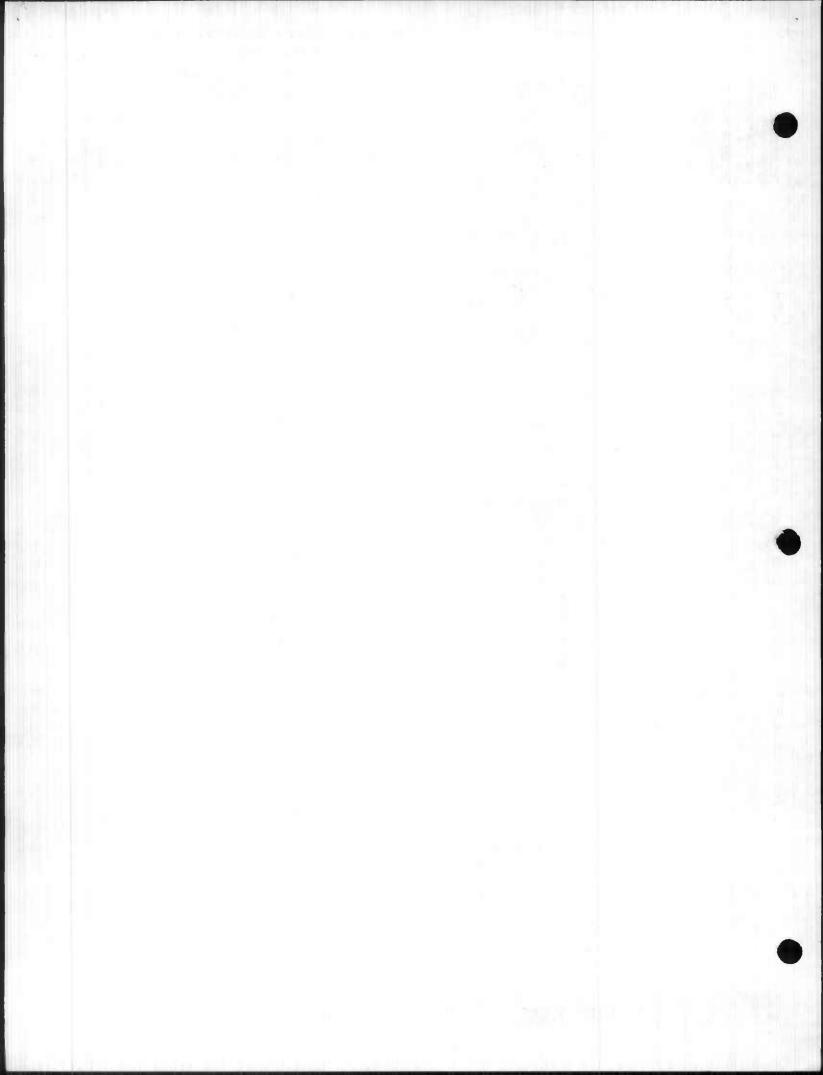
5 Sparks

State

Registrar

31. Date filed (Month, Dey, Year)

MAR 2 9 2000

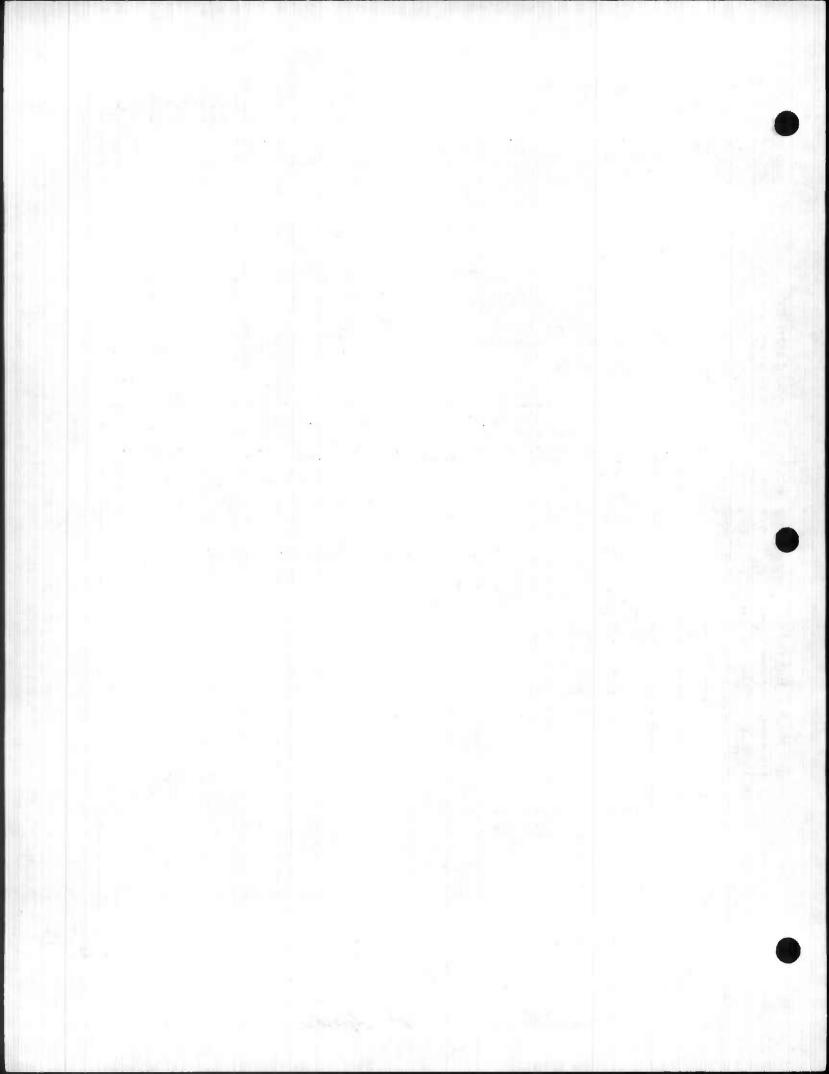


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Certin	ficate of	Death	Reg	J. No.		6
1. D	ecedent's Nama (First, Middle, Las		000	17	2	2. Data of Death Month	Day Y	3. Time of D	
ical	-,0HD		BER		th Chi Taura da	MARCH		5:5	5 PM
iner 48 i	Facility Name (If not institution, give Howard Cour	street and number) nty General Ho	osnital		Colum	Location of Death	4c. County of	peath pard	
	ocial Security Number 6. Se		last birthday)	f Under 1 Year lonths Days	If Under 24 Hrs Hours Min	8. Deta of Birth		Birthplace (State or l County) lary land	Foraign
Usu	al Residence of Decedent					1 5 - 7		2	
10a.	MD Howard	10c. C	ity, Town or Locati Marr	<sup>ion</sup> iottsvi	lle			10d. Inside City 1 ☐ Yas	
10e.	Street and Number 1526 Everlea Roa	- A		10f. Zip Code	1104	109	g. Citizen of Who	it Country?	
11.1	Marital Status	12. Was Decedent Ever in L	J.S. 13. Was			Specify Yes or No- to Rican, atc.)		American Indian,	
	Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas:		es, specify Cubi	an, Mexican, Puai Specify:	rto Rican, atc.)	Black, Specify:	White, atc. White	
	15. Decedent's Edu (Specify only highest grad		16a. Deceden	t's Usual Occup	ation during most of we	ndkina 16	6b. Kind of Busin	nass/Industry	
8	lementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired	during most of wo		Engir	eering	
17. [	Father's Name (First, Middle, Last)			-99.		ma (First, Middle, Ma		cering	
	John Carl Kimbe	er, Sr.				le Estelle		er	
	Informant's Name/Relationship (7)					ural Routa Number, ( rriottsvi]			
	Method of Disposition  1\( \bar{\text{\text{L}}}\) Burial 2	Removal trom Stata	Place of Disposition Cematery, cremete Oudon Pai	ory or other place		Date 20 3/31/2000		y or Town, Stata	
21.	Signature of Funeral Service Licens	Hailt				E & CHAPEI 784 (410)-			
238	Part1. Enter the disease, or comp shock, or heart tailure. List only o	ications that ceused the dea ne cause on each line.						Approximata Interval Betwee Onsat and De	een eeth
dise	nediata Cause (Final base or condition ulting in death)	ASPIR	ATION	O bu	EUMI	AINC		IWEE	×
Seq if an		DEN	or es a consequer	nce on:				2 YEA	RS
Seq if an	uentially list conditions, ny, leading to immediate se. Enter Underlying se (Disease or injury	Due to (	or as a consequer	nce of):					
resu	initiated events ulting in death) Last	Due to (d	or as a consequen	nce of):					
Part	II. Other significant conditions co				en in Part I.	23b. Did tob	•	bute to the cause of Probably 4 U	
	ACUTE R	ENAL FA	FILUK	5					
						24e. Was an performe		24b. Wara autopsy tin available prior to completion of cau of death?	
						1 🗆 Yas	2 the	1 ☐ Yas 2 ÛN	10
25.	Was case referred to medical examiner?	Apprilate		0.0		eth (Check only one)			
	1 Yes 2 Nor I		ER/Outpatient	3 DOA Oth	4 LI Nursing I	Homa 5 ☐ Rasiden			
1	5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	tnjury	28c. Injur Wor M 1□	Yas 2□No				
	I ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ioma, farm, street, fy)	, factory, office		City or Town,		or Rural Routa Numbi	9f,
29a.	Certifier 1 Check only one) 1 Medical Exami	nician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death oc ation and/or invest	curred at tha tir tigation, in my o	ne, date and place pinion, deeth occ	e, and dua to tha cau urred at the time, dat	se(s) and mann a and place, and	ar as stated. I dua to tha cause(s)	
	Signature and title of certifier	00 00 -		29c. Licens	-			Month, Day, Year)	41
20.4	Name and address of person who or	My MY	m 23e) (Time Bi	12	7909			H26,2	
5	, MAURERMO	9501 0L0	ANNAP	Bus R	D EU	JCOTT CI	TY MI	0,21042	٠
e 31. C	Data filed (Month, Day, Year)	32. Registrar's Sign	ature &	1					

DHMH 16 Rev 6/95



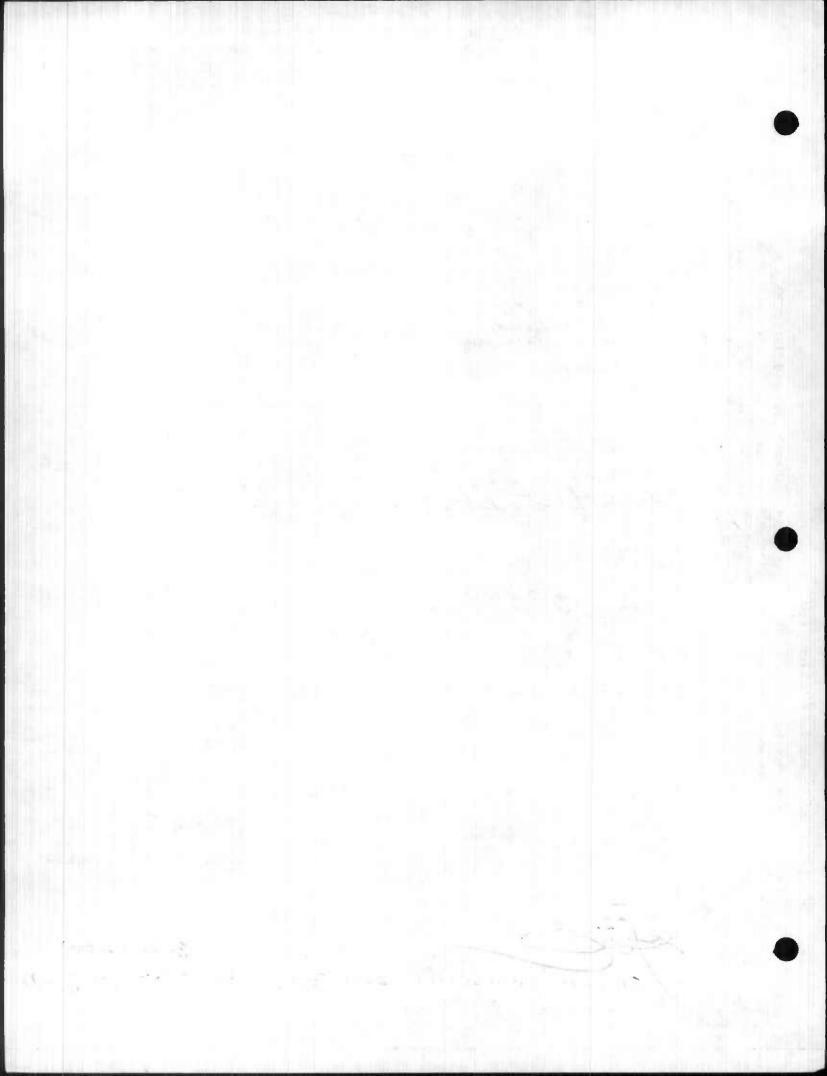
State of Maryland / Department of Health and Mental Hygiene

ician					Ce	rtificat	te or	Deam			Reg. No.			
ician	1. Decedent's Nama (First,	Middle, Las	t)							2. Deta of De	ath	V	3. Tima ol Dea	
	Socrates Lag	205								Month	Day Year 2h 24, 2000		11:14	
dical niner	4a Facility Nama (If not ins	_	streel and num	ber)		_		4b. City, To	wn, or Lo	cation of Deet		ly of Death	11.14	
iiei	Suburban Hos			Sale.				Bethe	odo					
	5. Social Security Number	6 Se	ex 7	. Age (In vrs.	last birthday)	If Unde	r 1 Year			8. Data of Bir	th	gomery	ace (State or Fr	
	577-18-5037 Usual Residence of Deced	11	M 2□ F	80		Months	Days	Hours	Min.	Sept 2	27, 1919	Count 1111	ace (State or Fo ny) nois	
		County		10c. Ci	ty, Town or Lo	ocation						10	d. Inside City L	
	Maryland Mor	itgome	ry	Sil	ver Spi				(7)			1 □ Yas 🏖 □ N		
1	1309 Midwood	1 D1 aa.				10f. Zip	Code 910				10g. Citizen of What Country? USA			
	11. Marital Status	Flace	12. Was Deced	ent Ever in L	,S. 13.			lispanic Ori	igin? (Sp	ecify Yes or No Rican, atc.)		ce - America	n Indian,	
	1 Never Married 2[3 Widowed 4 Dir		Armed Form 1 X Yes 2 If Yes, Give Year or Da	!□ No				an, Mexicar Specify:		Rican, atc.)	Black, Whita, atc.  Specify: White			
	15. De (Specify only	cedent's Edi	ucation de completed)		16a. Dece (Give	kind of wo	ork done	during mos	t of work	ing	16b. Kind of I	Businass/Indi	ustry	
	Elementary/Secondary (	1	College (1-	for 5+)	lite.	DO NOT u	se retire	d)						
	12			The little of	Super	cinte:	ndan						ernment	
	17. Father's Nama (First, M	liddle, Last)						18. Mothe	er's Name	a (First, Middle	, Maiden Suma	me)		
	William Lago	s						Hele	n Ka	ratzas				
1	19a. Informant's Name/Re		ype, Print)		19b. Maili	Db. Mailing Addrass (Street and Number or Rural Route Number, City or Town,					n, State, Zip	Code)		
	Ethel C. Lag	ros/ W	ife		1309	Mid	hoow	Plac	e. S	Silver Spring, MD 2091				
	20a. Method of Disposition	A		20b.	Place of Dispo	sition (Na.	me of		-, 0	Dete	20c. Location			
	1X Burial 2 Crem			ate	cemetery, cre				12	127100	0.17		1/10	
I	4 Donation 5 Ot 21. Signeture of Funeral S			Ga				meter		/2//00	Silver	Sprin	g, MD	
Medical Examiner	Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
	Part II. Other eignificant or	onditions co	dntributing to dea	th but not res	ulting in the u	nderlying o	causa giv	ven in Part I	l.	23b. Did	tobacco use c	ontribute to	the cause of d	
					ple					10	Yes 2 No	3 Prob	ably 4 Uni	
											an autopsy ormed?	eval	ra autopsy findi ilable prior to apletion of caus eath?	
п										1 🗆	Yas 2 XNo	10	Yes 210 No	
l		nedical						26. Place	of Deat	h (Check only	one)			
	25. Was case referred to m	axaminer?							ursing Ho	ma 5□ Rasi	dance 6 🗆 O	thar (Specify	)	
			1			28c. Injui Woo			28d. Describe	how injury occu	berni			
	axaminer? 1  Yes 2 No  27. Manner of Death 1 Natural 5   1	Pending nvestigation	28a. Date of (Month	Day roar)		М	rm, street, factory, office 28f. Location				n (Street and Number or Rurel Route Number, Town, State)			
	axaminer?  1 Yes 2 No  27. Manner of Death  1 Neutural 5 I  2 Accident  3 Suicide 6 0	Pending	(Month					Yas 2				ber or Rurel	Route Number,	
reduced our microscom. To be completed	axaminer?  1 Yes 2 No  27. Manner of Death  1 Netural 5 1  2 Accident i  3 Suicide 6 0  4 Homicide	Pending rivestigation Could not be determined	28e. Place of building	I Injury - At h , atc. (Special ast of my kno	wledge, deati	reet, factor	y, office	me, date an	d place,	City or To	wn, State) cause(s) and n	nannar as sta	nted.	
	axaminer?  1 Yes 2 No  27. Manner of Death  1 Netural 5 1  2 Accident i  3 Suicide 6 0  4 Homicide	Pending rivestigation Could not be determined	28e. Place obuilding	I Injury - At h , atc. (Special ast of my kno	wledge, deati	reet, factor	y, office at the tir , in my c	me, date an opinion, daa	d place,	City or To	cause(s) and n	nannar as sta , and due to	ited. the cause(s)	
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	axaminer?  1 Yes 2 No  27. Manner of Death  1 Natural 5 1  2 Accident  3 Suicide 6 0  4 Homicide	Pending rivestigation Could not be determined	28e. Place of building	I Injury - At h , atc. (Special ast of my kno	wledge, deati	reet, factor	at the tir , in my c	me, date an opinion, daa se number	d place,	City or To	cause(s) and n	nannar as sta , and due to ned (Month, E	ated. the cause(s)	

DHMH 16 Rev 6/95

3/24/00

Socrates



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amended item #19a per fh g782 4/12/2000 ah 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** March 23, 2000 8:00 AM Yong Joo Lee /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 13610 Cedar Creek Ln Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** Days Hours Months MM 2DF Director 229-17-5160 51 Feb 8, Korea Usual Rasidance of Decedant the Maryland 10b. County 10a. Steta 10c. City, Town or Location Show 10d. Inside City Limits than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13610 Cedar Creek Ln 20904 Korea death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, 11 Merital Status Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 ☐No If Yes, Giva 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Asian Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry el Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) 4 Operator Liquor Store Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If Item 27 te marked other eny Injury or other treumatic event pages. 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Sang Kyu Lee Ae J. Yang 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) BYUNG LEE/WIFE Dyung Lee/Wil 13610 Cedar Creek Ln, Silver Spring, MD 20904 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Norbeck Memorial Park | Mar 25 Olney, MD 21. Signature of Funaral Service Licensee 22. Nama and Address of Fecility Hines-Rinaldi Funeral Home Ola Donne Ol 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. Distant on a cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel 9 months , Metastatic cancer to liver & peritoneal cavity disaase or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner 9 months Cancer of unknown primary physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Ceuse (Diseesa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): esn Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 2 1 Yes 2 No 3 Probably 4 Unknown Ascites, liver failure signed b þ Records, law requires 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to Completed completion of cause of death? paga 2 The 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was casa relarred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☑ Residence 8 ☐ Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 X Natural 5 Panding ne Hospital or Attending n 24 hours after death. ne Funersi Director: Afte pletely filled in by the fun 1 Yes 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Plece of Injury - At homa, larm, street, factory, office building, etc. (Specify) 4 D Homicida edicai 29a. Cartifian 1 🔀 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end manner steled. (Check only one) easing 29d. Dete signed (Month, Day, Year) 29b. Signatura and titla of certiliar 29c. License number 7000 Munno 30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Deta liled (Month, Dey, Year)

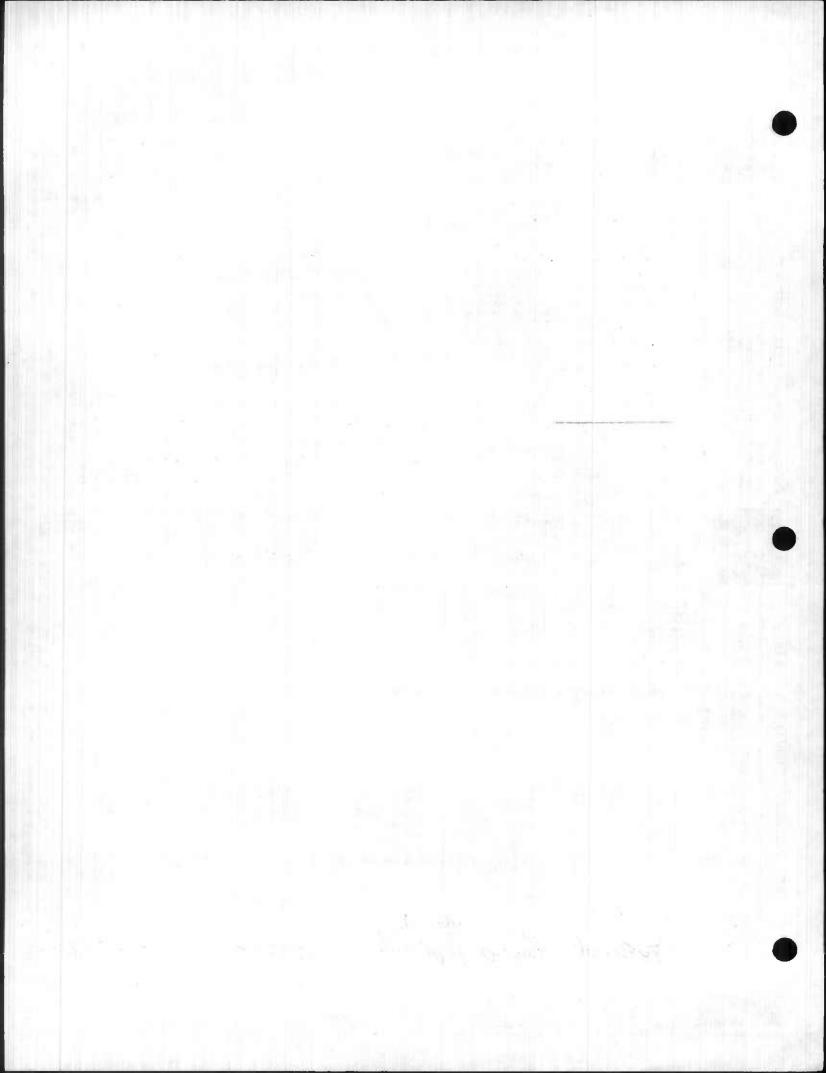
MAR 28

2000

20852

Daniel I. Kim, M.D. 121 Congressional Lane, #318, Rockville, Maryland

32. Registrar's Signatura



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Day Month March 25, Karen A. Lindstrom 2000 8:00 AM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth (Month, Dey, Year) June 16, 1960 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months 1 M 2 F 534-74-5324 39 Yrs England Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1 ☐ Yes 2 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 16519 Grande Vista Drive 20855 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Derek W. Purton Joan P. Sparrow 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Eric Jon Lindstrom/Husband 16519 Grande Vista Drive, Derwood, Maryland 20855 Date 27 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Mar. Montgomery Crematorium, Inc. 2000 4 ☐ Donetion 5 ☐ Other (Specify) Bethesda, Maryland 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funerel Service Library Rockville, Inc., 300 Rockville, Maryland burn M00672 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Finel diseesa or condition rasulting in deeth) Due to (or as e consequence of): CINOMATOUS MENINGITIS CANCER 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was en autopsy performed?

Physician /Medical Examiner

the

page 2

after deat Director:

24 hours

To the Hosp within 24 ho To the Fune completely fi

The law requires that the death certificate be executed

Vital

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

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Baltimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

27 is marked or remarks evi

ortant of Health an ortant if hem 27 is my lary or other to

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes

1 TYas 2 No

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth

Hospitel: 5 Pending investigation

28a. Date of Injury (Month, Day Year)

Inpatient 2 ER/Outpatien1 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 T Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

13. HENDRICKS MY OLYN

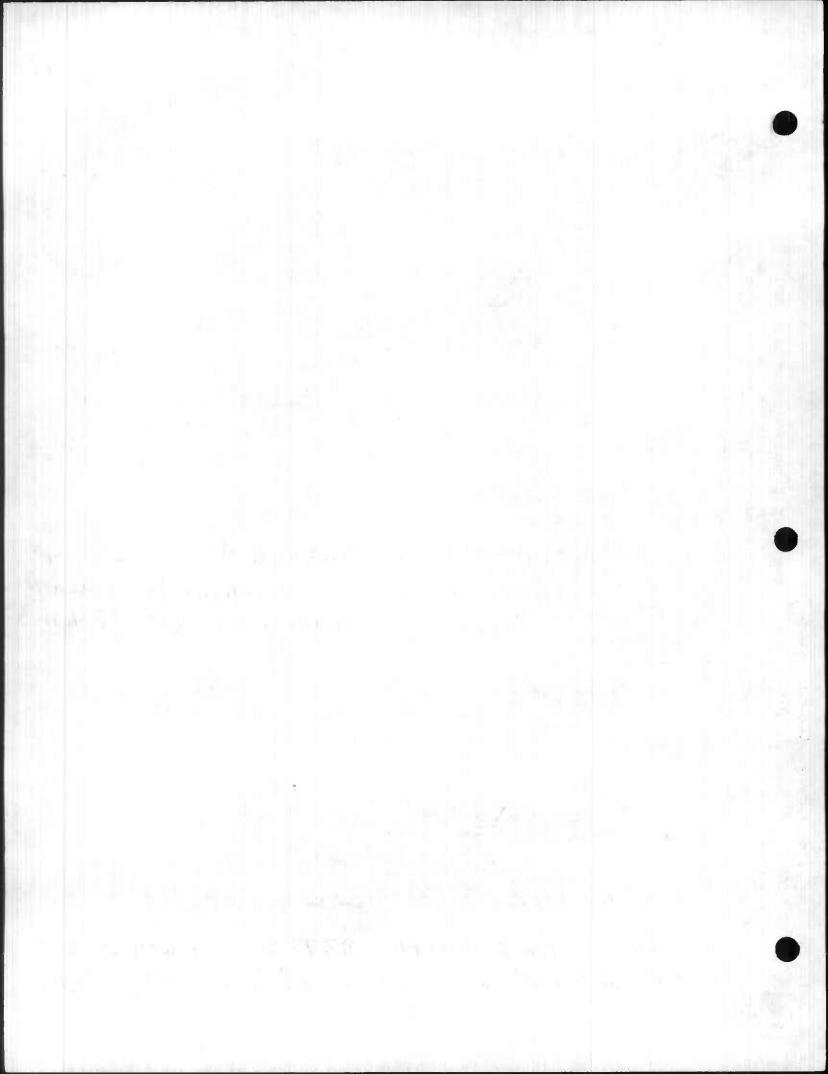
6410 ROCKLEDGE DR

State Registrar

10

31. Date filed (Month, Day, Year) MAR 2 7

32. Begistrar's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Gania F. Lisak 2000 March 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Hebrew Home 6121 Montrose Rd. Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 M F Months Days Hours Yrs. 228-98-1667 92 Dec. 1, 1907 Poland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes XX No Fairfax Annandale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8422 Briar Creek Dr. 22003 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 TNo If Yes, Give Year or Dates: 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 □ Never Married 2 □ Merried 1 ☐ Yes 2 No Specify: 3€Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Joseph Fish Lea Fish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shoshana Carroll/ Daughter 8422 Briar Creek Dr. Annandale VA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel frnm State 4 Donetion National Crematory Mar. 29, 2000 5 Other (Specify) Falls Church, VA 21. Signature of Buneral Service Lice Name and Address of Facility Affordable Funeral Services P. O. Box 542 Merrifield, VA 22116 23a. Part1. Enter the disease, or complications that caused the death. So hot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final pul monany disease or condition resulting in death) -dro -Due to (or as a consequence of): de Due to (or as e ponsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No ti da 25. Wes case befored to medical examiner? 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

permit. Page Department of Important: If any injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23s or 28s-f show edical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours eftar death neart of Health and Mental Hygiene.
ant: If Ilem 27 Is marked other than "natural", or Itema 23, unit: If Ilem 27 is marked other than "natural", or them 23, uny or other treumatic event, are Mendical Examination must

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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> physician and the burial-transit BS esn signed by t

Physician/Medical Examiner

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Certification:

edical

317 NO

1 ☐ Yes

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

thet the deeth certificate be axecuted Division of Vital Records, P.O. Box 68760, certificate or Attending Physician: this funeral filled in by 24 hours after of Funeral Direct

Hospital

within 2

State Registrar

Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier

5 Pending investigation

6 Could not be determined

**MAR 3 0** 

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

28c. Injury at Work?

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year)

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

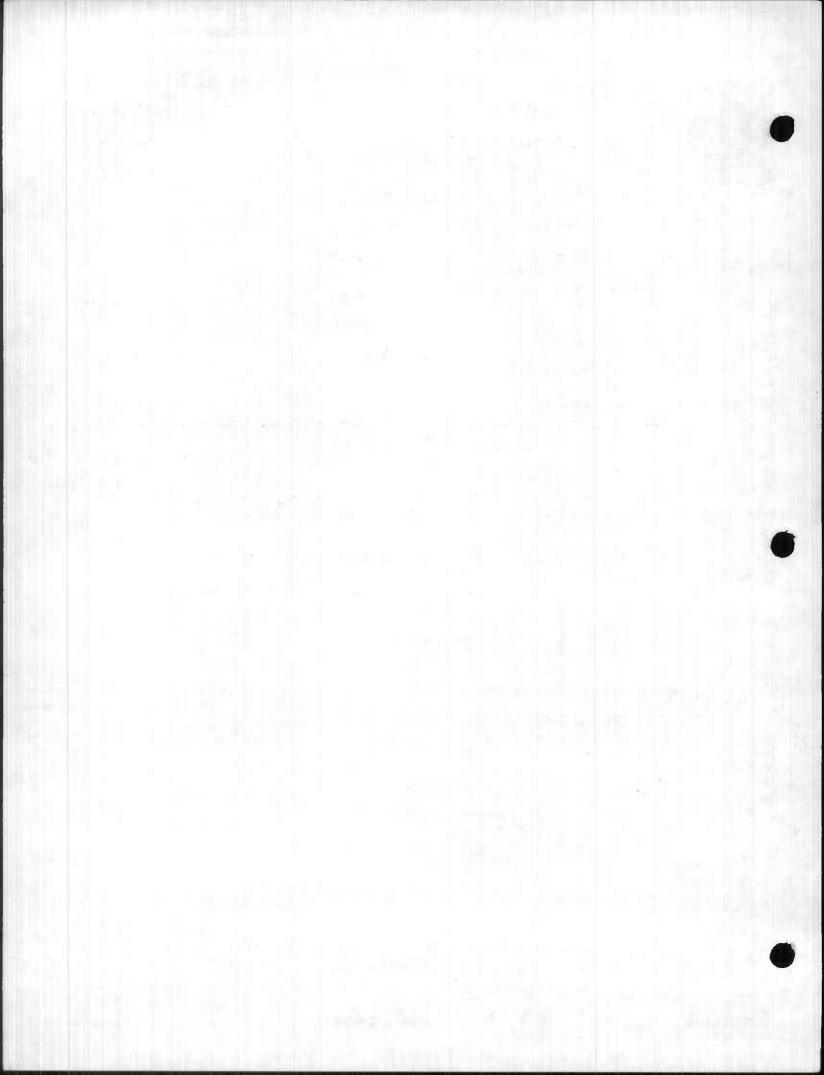
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mont port 31. Date tiled (Month, Day, Year) 32. Registrer's Signeture

Hospital:

aschulle

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end menner es steted.

**DHMH 16 Rev 6/95** 



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death MARCH 6.10 PM Elizabeth Gosamond 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll County General Hospital Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 1□M 20F Months 93 Yrs. 129-10-1198 Pennsylvania Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carrol 1 Yes 2 No pstead 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 1156 Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status 12. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 → Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) S&H Green Stamps Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Kingsley Emma Heller 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Daniels, niece 1156 Caton Road, Hampstead, MD 21074 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremations 3/29 Hampstead, MD M00723 22. Name and Address of Facility 21. Signature of Paneral Service Licenses Eline Funeral Home teve 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Right Lower Loke Preumonia 4 DAYS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed Box 68760. signed by the a Division of Vital Records, P.O. this certificata

**Physician** 

/Medical

Director

Funeral

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Completed

Be

**Funeral** 

Director

28e-7 must be notifi-

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Hygiene.

and Mental F.

Department of Health as Important: if them 27 is any injury or other trau

**Physician** /Medical

Pages 1 and 2 should be filed within 72 hours after

21215-0020

Baltimore, Maryland

Physician/Medical Examiner Be Completed by Medical Certification: To

director,

the funeral

completely filled in by

After

death.

To the Hospital or Attendition 24 hours after death. To the Funeral Director: A

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.

Hospital: 1 Inpatient 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Menner of Death 5 Pending investigation 1 Natural

6 Could not be

28b. Time of

28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

29c. License number D 52035 29d. Date signed (Month, Day, Year) 2000 March

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINU CHACKO 295 Stoner Avenue

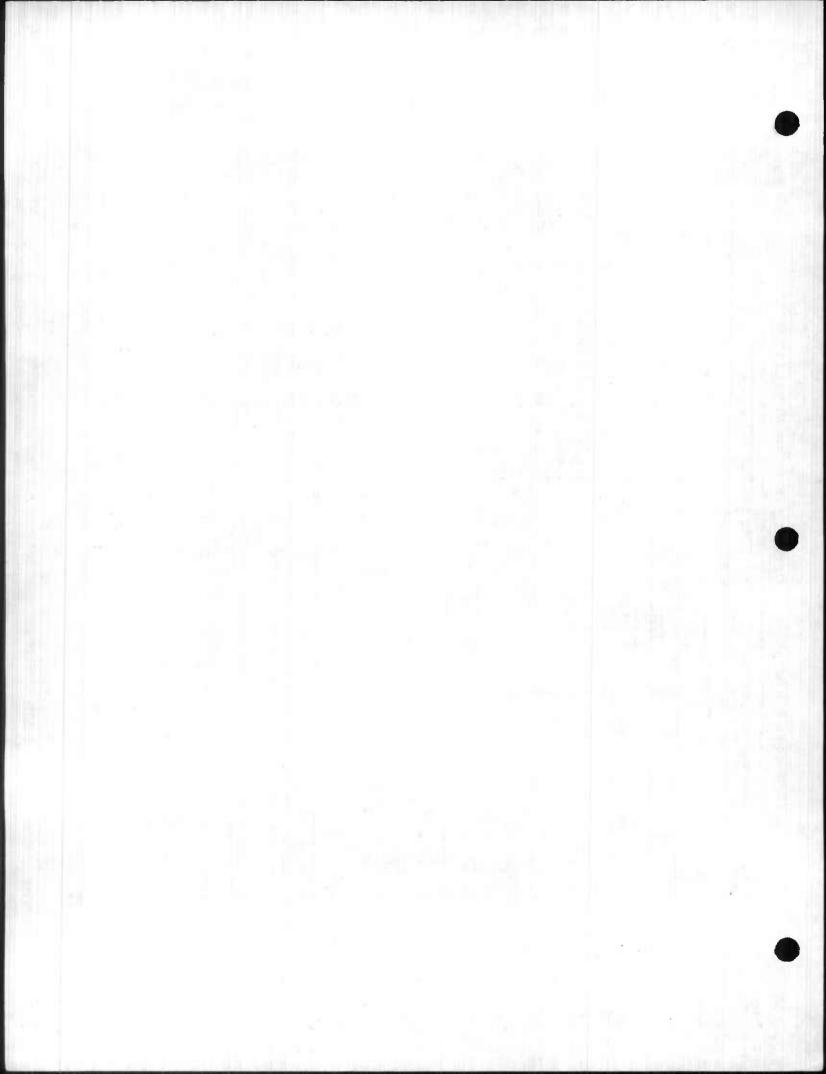
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State Registrar

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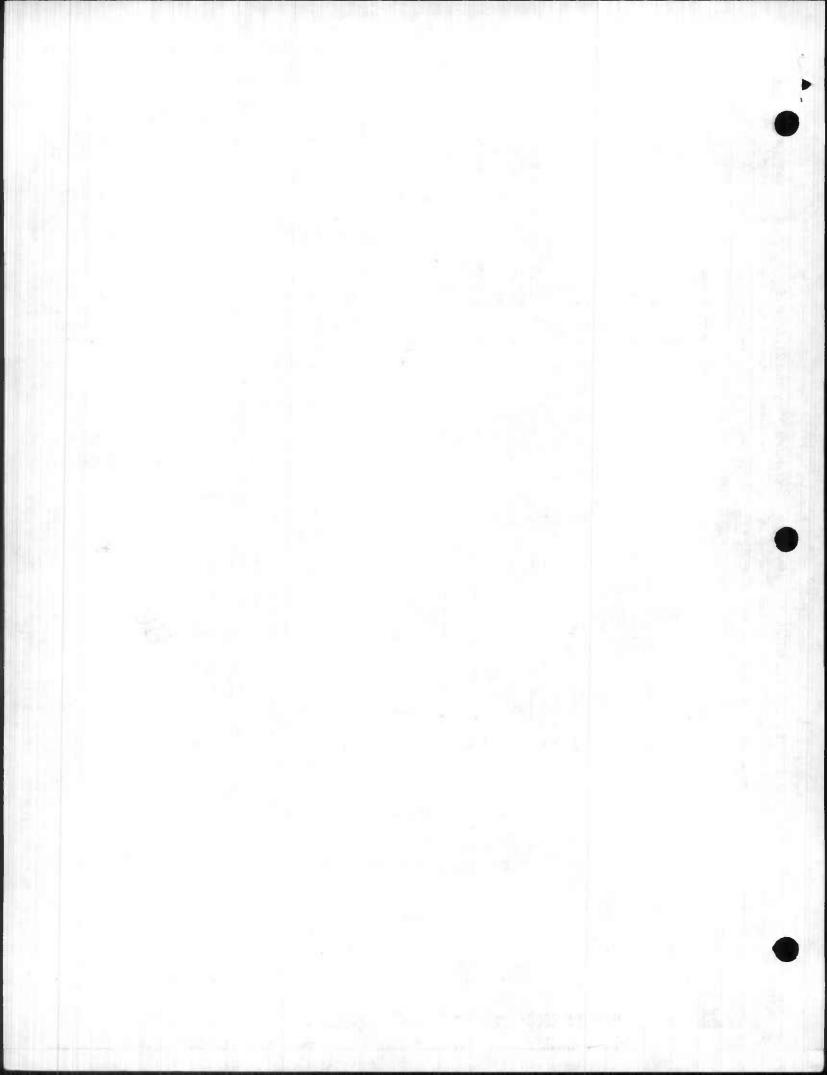




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n	s Name <i>(First, Middle, L</i> Verna K.					Month	2. Date of Death Month Day 15 Year March 26, 2000					
	ame (If not institution, g		?	1 11-0 0		Town, or Location of D	Location of Death 4c. County of Deeth					
		unty (	ge (In yrs. last b	11			trainstr Car					
130-2	3–1160	1□M 2₽F	82	Yrs. Months	Days Hour	s Min. (Month,	Day, Year)	7 Mar	rthplace (State or country) Cyland			
10a. State	10b. County		10c. City, Tov	wn or Location					10d. Inside City			
10e. Street	Carro	oll			Woodb	ine			1 ☐ Yes 2			
10e. Street 7539	Morgan Road	đ		10f. Zip	21797		10g. Citiz	U.S.A.				
11. Marital		12. Was Decedent	Ever in U,S.	13. Was Dece	dent of Hispanic city Cuban, Mexi	Origin? (Specify Yes or can, Puerto Rican, etc.)		14. Race - Am Black, Whi	erican Indian,			
_	r Married 2 Married		No	1 🗆 Yes					hite			
	15. Decedent's I (Specify only highest g	Education		a. Decedent's Usu	at Occupation	nost of working	16b. Kir	6b. Kind of Business/Industry				
Elementa	/Secondary (0-12)	College (1-4or	5+)	life. DO NOT u			Carı	roll Co	.Educati			
17. Father's	Name (First, Middle, Las	•			18. Mo	ldle, Maiden	Sumame)					
Ken	y Tobias Ho	-		N. 84.W 844	Jean		T	7: 0 (1)				
	nt's Name/Reletionship			b. Mailing Address  Casino	-							
	of Disposition	□Removal from State	20b. Place of	of Disposition (Na	ne of	Date	20c. Lo	cation - City or	Town, State			
4 🗆 Do	ation 5 Other (Spec	eify)	The second second	owridge M					e, MD			
21. Signatu	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
shock, or heart feilure. List only one cause on each line.  Immediate Cause (Final disease or condition												
disease of resulting in	ondition	a	- /	0					かって「			
9 77 9	1		Due to (or as a	a consequence of):					i i			
if any, leed	list conditions, g to immediate	D	Due to (or as a	consequence of):					t			
Sequentiall if any, leed cause. Ent Cause (Dis that initiate resulting in		C	Due to (or as a	consequence of):					t			
E Testining in	satri) Last	l d							i I			
	elanificant conditions	contributing to death I	out not resulting	In the underlying	ause cinen in De	226 1	Oid tobacco	uee contribut	to the cause of			
Part II. Othe	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute  23b. Did tobacco use contribute											
Part II. Other	17 1/21	Delp Vein thrun			cm nh							
Part II. Other	12 Vei	800' 1	1	ا رداها	cmph.	24a. V	Vas an autoo	sv 24b.	Were autopsy fin			
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Part II. Other Dee	p Vei	eriphe	val v	Joseph .	in di	sian,	erformed?	sy 24b.	available prior to completion of car			
De s S en Hy 25. Was de externine		eniphe miphe	val V	Joseph	Other _	ace of Death (Check or	Yes 25	(No	available prior to completion of car of death?			
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D.Q. & S. Wed de examine 1   Yes 27. Manner 15 Net	2 No Death al 5 Pending investigation of Could not	28a. Date of Inj (Month, Date of Inj (Month, Date of Inj	ury 28b.	Time of trijury	OA Other: 4 Page 28c. tnjury at Work?	ace of Death (Check or Nursing Home 5 P P 28d. Descr	Yes 25  Ny one) lesidence 6 be how injury	No Other (Spo	available prior to completion of car of death?			
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DHMH 16 Rev 6/95

Verna Kenley



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 12 Day 2000 Maude Elizabeth Lind 10:45 PM 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street end number) 4c. County of Deeth 104 Creagerstown Rd. Woodsboro Frederick 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 7. Aga (In yrs. lest birthdey) Birthplace (Stata or Foraign Country) 1□M 2⊠F Months Deys Hours Yrs 220-30-9324 66 Aug. 5, 1933 Maryland Usual Residence of Dacadent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Frederick Woodsboro 10e Street and Number 10f Zlo Code 10g. Citizen of Whet Country? 21798 104 Creagerstown Rd. U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Collaga (1-4or 5+) Elementery/Secondery (0-12) 12 cafeteria worker public schools 18. Mother's Neme (First, Middle, Maidan Sumema) 17. Fether's Neme (First, Middle, Last) Clarence M. Bostian Sr. Marie Lola Jackson 19b. Meiling Address (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Roy L. Lind - husband 104 Creagerstown Rd., Woodsboro, MD 21798 20b. Placa of Disposition (Nema of cametery, cremetory or other place) 20e. Method of Disposition March 15 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Chapel Cemetery 2000 Libertytown, MD 21. Signature of Funar-I Sarvice Licent 22. Name end Addrass of Fecility Hartzler Funeral Home 404 S. Main St., Woodsboro, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset end Deeth 48 mo Immediata Causa (Final disease or condition resulting in death) Due to (or as e consequance of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events rasulting In daath) Last Due to (or es e consequença of): Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? completion of causa of daeth? 1 Yes 2 No 1 □Yes 2 □ No 26. Pleca of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of 28d. Describe how Injury occurred 1 Neturel

Physician /Medical Examiner Examiner physician and the buriel-trensit The lew requires that the death certificate be executed Physician/Medicai 80

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

than "natural", or items 23s or the Medical Examiner must be a

permit. Pages 1 and 2 should be filled within 72 hours after dear Department of Health and Mental Hygiene. Important: If them 27 is marked other to any injury or other treaming other any single.

Directo MD

Funeral

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Completed

attending p signed by the a d be detached f should I is certificate has build director, page 2 s al or Attending Physician: The setter death.

In Director: After this certificated in by the funeral director, pe

by

Completed

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760.

25. Was case raferred to medical axaminar? 1 Yes 2 No 27. Mannar of Death

2 Accident

3 Suicide

29e. Certifier

4 Homicida

(Check only one)

5 Pending invastigation

8 Could not be detarmined

28a. Date of Injury (Month, Dey Year)

28a. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury et Work?

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowladga, daath occurred et tha time, date and place, and due to the causa(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred et tha time, dete end placa, and due to the cause(s) end mennar stated. 29b. Signature and Jiffe of certifian

29c. Licanse number

29d. Data signed (Month, Day, Year)

Ques 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

ANGER RESEARCH 01041650 Orleans St., Baltimore, MD21231

3-22-00

31. Data fited (Month, Day, Year)

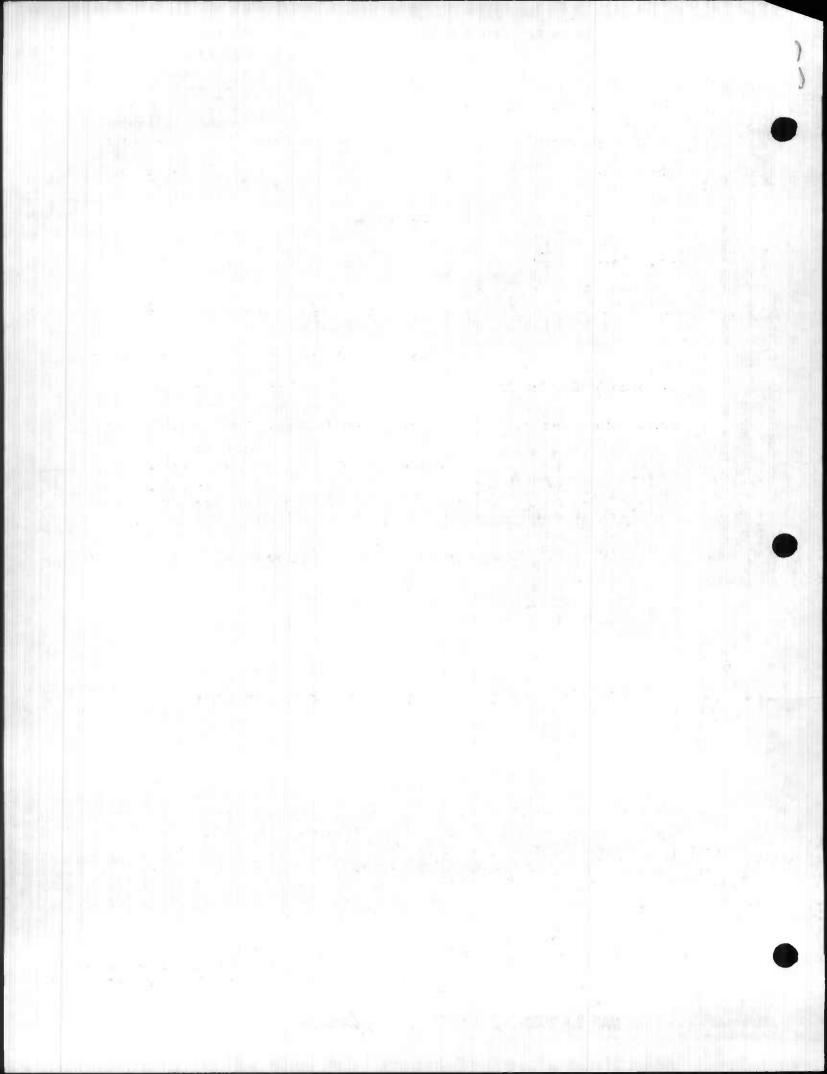
32. Registrer's Signeture

State Registrar

MAR 2 8 2000

e Funeral Di

within 2 To the F



State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#8 PER NFMNT. G782 4-21-2000 JAB 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Dey 2000 **Physician** Marjorie Jane Mahy 11:40 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examinér 6917 Persimmon Tree Road Bethesda Montgomery | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth 3\_26—33 | 9. Birthplece (State or Foreign (Months | Devs | Hours | Min. | (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2\ F 475-34-4738 67 Yrs. Minnesota **Director** Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 2 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be r 6917 Persimmon Tree Road 20817 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Meritel Status filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes: 1 Never Merried 2 € Merried Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: À 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) International Relations Specialist 4 Federal Agency 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be should be and Mental marked William R. Kirkpatrick Hattie Lea 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s ment of Health an ã David C. Lyman/Husband 6917 Persimmon Tree Road, Bethesda, Maryland 20817 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete March 30, 1 ☐ Buriel 2 K Cremetion 3 ☐ Removel from Stete Montgomery Crematorium, Inc. 4 □ Donetion 5 □ Other (Specify) 2000 Bethesda, Maryland 21, Signeture of Fyneral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, mpo my il M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23e. Pert1. Enter the disease, or complete ions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final Metastatic Breast Cancer 7 Years diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Physician/Medical Examin The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest Due to (or es a consequence of): pur Box 68760. attending physician for use as the buna Due to (or es e consequence of) Division of Vital Records, P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown P 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy page 2 should performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 No Residence 6 Other (Specify) To 1 Yes 2 No After this 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. eral Director: A filled in by the fo death. 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 within 24 hours a To the Hospital 1D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29a. Certifier edical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certified D22775 March 28, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

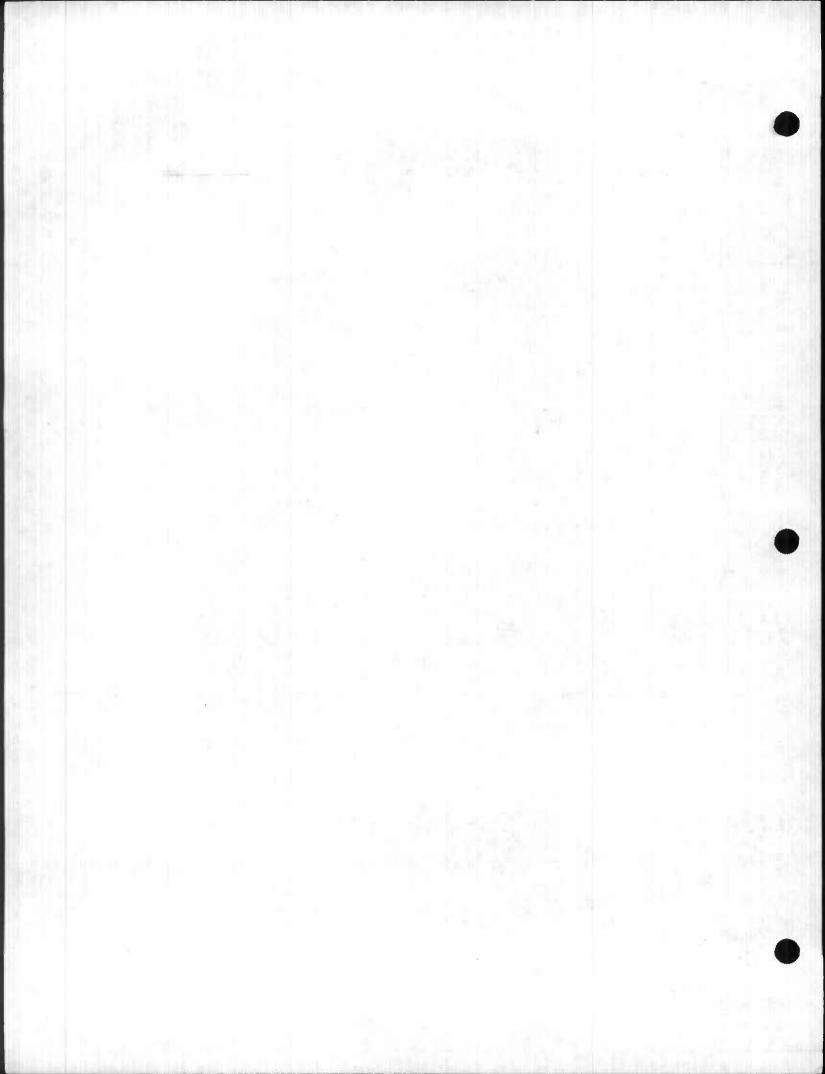
Frederick G. Barr, M.D., 5454 Wisconsin Avenue, #1345, Chevy Chase, Maryland 20815
31. Dete filed (Month, Dey, Year)
32. Registrer's Signeture

<sup>4</sup> State Registrar

MAR 3 1 2000

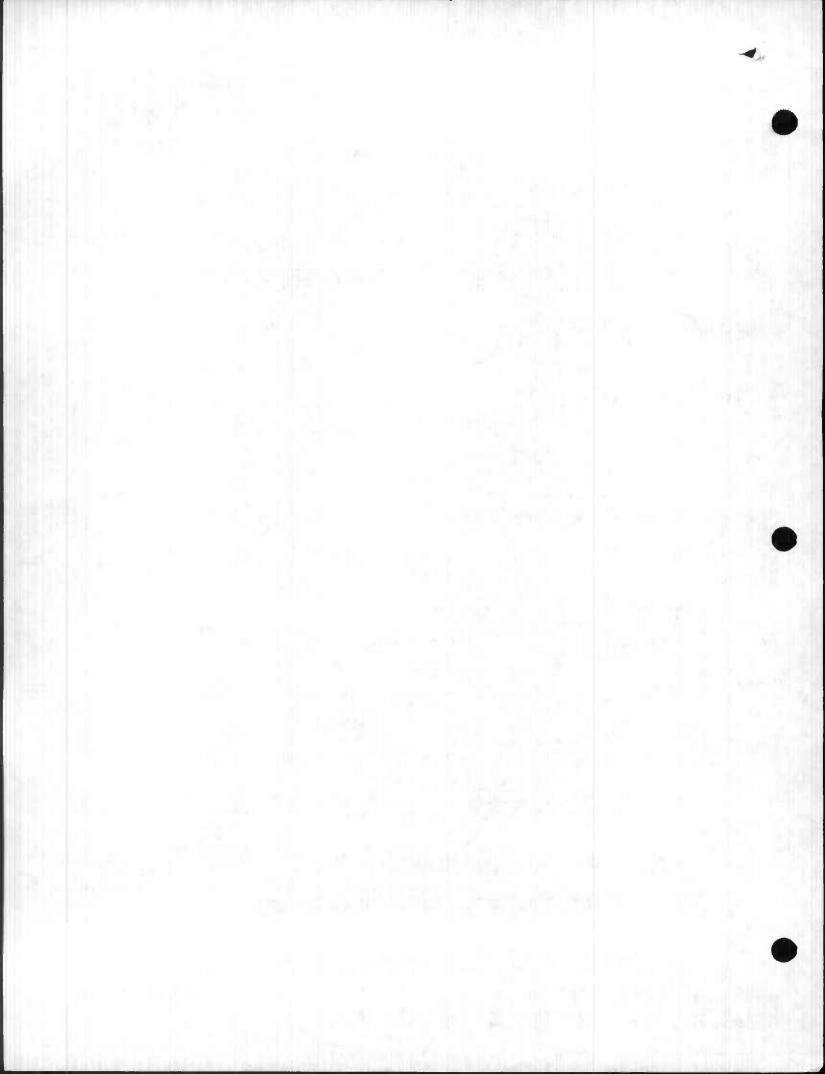
32. Registrer's Signeture

B. Sparks



State of Maryland / Department of Health and Mental Hygiene 00 11785

TIM	NOI			C	ertificate	of L	Death		F	lea. No.			00
		1. Decedent's Neme (First, Middle, La	ist)	-					2. Dete of Dea	ith		3. Time o	f Death
	Physician	Brian Kahn Malmo	n						Month	Day	Yeer		
	/Medical	4e Facility Neme (II not Institution, gir				41	b. City. To	wn, or L	MARCH ocation of Death	24, 200 4c. County		16:50	) PM
	Examiner												
-		12004 STARVIEW 5. Social Security Number 6.		n yrs. last birthde	If Under 1	Yeer	POTOM If Under	IAC 24 Hrs.	8. Dete of Birth	MONTO			or Foreign
	Funeral	The state of the s		2 Yrs.		Days	Hours	Min.	(Month, De)	, Year)		iace (State try)	
	Director	577-82-8196 Usual Residence of Decedent	-	, dem				-	July 21	y 21, 1977 Washington,			on, DC
	and	10a. State 10b. County	10	Oc. City, Town or	Location						11	Od. Inside C	City Limits
	Aery Or	MD Montgo	morry	Potomac								1/2 Yes	2 No
	with the Mer s or 28a-f el be notified Director	MD Montgo	mery	LOCOMAC	10f. Zip C	anda .				log. Citizen of V	What Coun	to/2	
	D P Q	12004 Starview (	+			2085	4				U.S.A.		
	Aurs after deeth with the Meryland st., or thems 23e or 28ed show Examiner must be notified at by Funeral Director		,	-t- He la				-1-0 (0-	:4. W Ala	14 Doo	a - America	an Indian	
	Per de	11. Merital Status	12. Was Decedent Eve Armed Forces?	ir in U <sub>i</sub> S.	If Yes, specif	y Cubar	n, Mexican	, Puerto	ecity Yes or No- Rican, etc.)		ck, White,		
20	72 hours after natural, or he need by Fu	1 Never Merried 2 Merried	1 Tes 2 No		1 🗆 Yes 2	No No	Specify:			Specify	wh	ite	
21215-0020	n 72 hours natural, notral Ex	3 Widowed 4 Divorced	Year or Dates:							101 101 1 10			
5	led within 72 ho tygiene. In the medical Completed	15. Decedent's E (Specify only highest gr	ducation ade <i>completed</i> )	16a. De	cedent's Usual ve kind of work b. DO NOT use	done d	uning mos	t of work	ring	16b. Kind of Bu	usiness/ind	ustry	
12	B B B	Elementary/Secondery (0-12)	Coilege (1-4or 5+)	III 6	Stude					C+	udent		
2	Co Trans	42 Family Name (First 1844)	3		Stude		18. Mother's Neme (First, Middle, Maiden Sumame)						
Maryland	De dott	17. Father's Neme (First, Middle, Last				. 1				Maiden Suman	16)		
K	Men Men To To	Stuart Edward Ma							Kahn				
lar	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiona. Important: if item 27 is marked other than "naturally jury or other traumatic event, the Medical place.	19a. Informant's Name/Relationship	Type, Print)			ess (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Starview Ct., Potomac, MD 20854							
2	and saith	Joanne Milobsky	Potomac	, MD 20	854								
Baltimore,	一五章	20a. Method of Disposition		20b. Piace of Dis	position (Name remetory or oth	e of ner pleca	a)	1	Dete	20c. Location -	City or To	wn, Stata	
Ĕ	Pagent: H	1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci	S	Mar.26, 2000 Olney, MD									
=	nit.	21. Signature of Funeral Service Lice	nsee		22. Name and				2000				
ä	Departing Department of the partment of the pa	10			g Memorial Chapels, Inc.								
		23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.											
ξ,		shock, or heart feilure. List only	one cause on each line.			or ay mag	,					Approxima Intervel Be Onset and	tween
A	Physician /Medical	Immediate Cause (Final	1-4	0 ,			-11	•	1				
	Examiner	disease or condition resulting in death)	o. Intro	rel /	hust	0	-60	m	d				
		resulting in douting	Du	e to (or es a con:	sequence of):						1		
	executed in and hial-transit	La Park III	h								i		
	and trans	Sequentially list conditions,	Due	e to (or as a con:	sequenca of):								
o	ian a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):											
68760,	eath certificate be executed ettending physician and I for use as the bunial-transit clan/Medical Examir	Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
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Вох	endir use		d								1		
	es that the death or igned by the ettend be detached for us by Physician/	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying car	use give	n in Part I		23b. Did t	obacco uae co	ntribute to	the cause	of death?
0	that the ed by the detache								10	res 2□No	3 Prot	ombly 4	Unknown
0	= 00												1
Vital Records,	requires ween sign hould be hould be									an autopsy	24b. We	ere autopsy	findings
000									perfo	med?	COI	eilable prior	
Se Se	2 2 0	S + 11 - 11 77 - 1							1	/	3	deam	25
<u></u>	Corr								121	'es 2□No	12	Yes 25	1 No
Ë	Physician: The I this certificate hural director, page	25. Was case referred to medical examiner?	14-1-9-1			100		of Dea	th (Check only o	ne)			
of	this of the sal direction To	1 XYes 2 No	Hospitel: 1   Inpatient	2 ER/Outpe			4LINU	irsing H	ome 5 A Resid			1)	
	ng Ph ter th neral	27. Manner of Deeth 1 Neturel 5 Panding	28a. Date of Injury (Month, Dey Yo	ear) 28b. Time Injur	of 28	c. Injury Work	at	,	28d. Describe t	ow injury occur	red		
Division	after deeth.  Director: After Jin by the funer ertification	2 Accident Investigation	1 0000 31 91 100	164	OMR	101	res 20	No	Sul	r 4 shot	sug		
5	Atte de	3 Suicide 6 Could not to determined		- At home, farm,	street, factory,	offica			28f. Location (S City or Tox	Street and Numb	ber or Rure	I Poute Nu	mber,
0	tal or Attending P rs after deeth. el Director: After t led in by the funer: Certification:	- Carronnaide	building, etc. (c	эрвину	how	_			PX	1 =	47/0		a Court,
	Hospital 24 hours Funeral stely filled dical C		nysician: To the best of m							ceuse(s) and ma	anner es si	tated.	
	To the Hospital or Atl within 24 hours after of To the Funeral Direct completely filled in by Medical Certifil	(Check only 2 Medical Example)	miner: On the basis of example and menner steted		investigation, i	in my op	oinion, dea	th occur	red at the time,	dete and placa,	and dua to	the ceuse	(s)
	within 2 To the comple	29b. Signeture and title of certifier			29c.	License	number			29d. Date signe	d (Month,	Dey, Year)	
	/	16.0.11	11.			OCM	E			MARCH 2	5. 20	000	
	5	Mederate (	( The			OCT-11				. IF MICH Z	اع رد	,00	
		30. Neme end eddress of person who	completed cafuse of death	h (Item 23a) (Typ	e, Print)								
		THEODILGM, KING		111	Penn S	itre	et, E	Balt	imore, M	laryland	1 2120	)1	
	State	31. Date filed (Month, Dey, You)	32. Registrar's	Signeture									
	Registrar	1180 GE 79 1	11111 Pro-100	~~ /7	A COL	The Mary							



State of Maryland / Department of Health and Mental Hygiene Amend #10f, 19b, 4/7/2000, JW, Mont. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Dey Month Year **Physician** March 25, 2000 Armen Mangasarian 3:45pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY tt Under 1 Yeer | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. 214-82-8245 82 Director Aug. 18, 1917 Iran Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothing at 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 20878 8 238 20875 714 Quince Orchard Blvd. #102 Funeral United States heme 14. Reca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 28X Merried Maryland 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 Widowed 4 Divorced "naturel". White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Engineering 4 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 ie marked oths any injury or other traumatic evant. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Boghos Mangasarian Iskohie Babajanian 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 20878 714 Quince Orchard Blvd. #102, Gaithersburg, MD 20875 Mary B. Manasarian (Wife) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/30/00 Rockville, Maryland Parklawn Memorial Park 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert tailura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Causa (Finel disease or condition rasulting in death) /Medical Aspiration Pneumonitis 8 Days Examiner Dua to (or es e consequence ot): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence ot): Box 68760, Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yaa 2 No 3 Probably 4 Unknown Congestive Heart Failure, Renal Failure, Diabetes Records, þ 24b. Wera autopsy tindings Be Completed 24a. Wes an autopsy evailable prior to completion of cause of death? performed? pege 2 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No certificate of Vital is or Attending Physicism: The state death.

It Director: After this certificated in by the luneral director, pr 25. Was casa raferred to medical 26. Place of Death (Check only ona) Hospitel: 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Mannar of Death 28b. Tima ot 28c. Injury et Work? 28d. Dascribe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, straet, tactory, office building, etc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours at To the Funeral DI completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

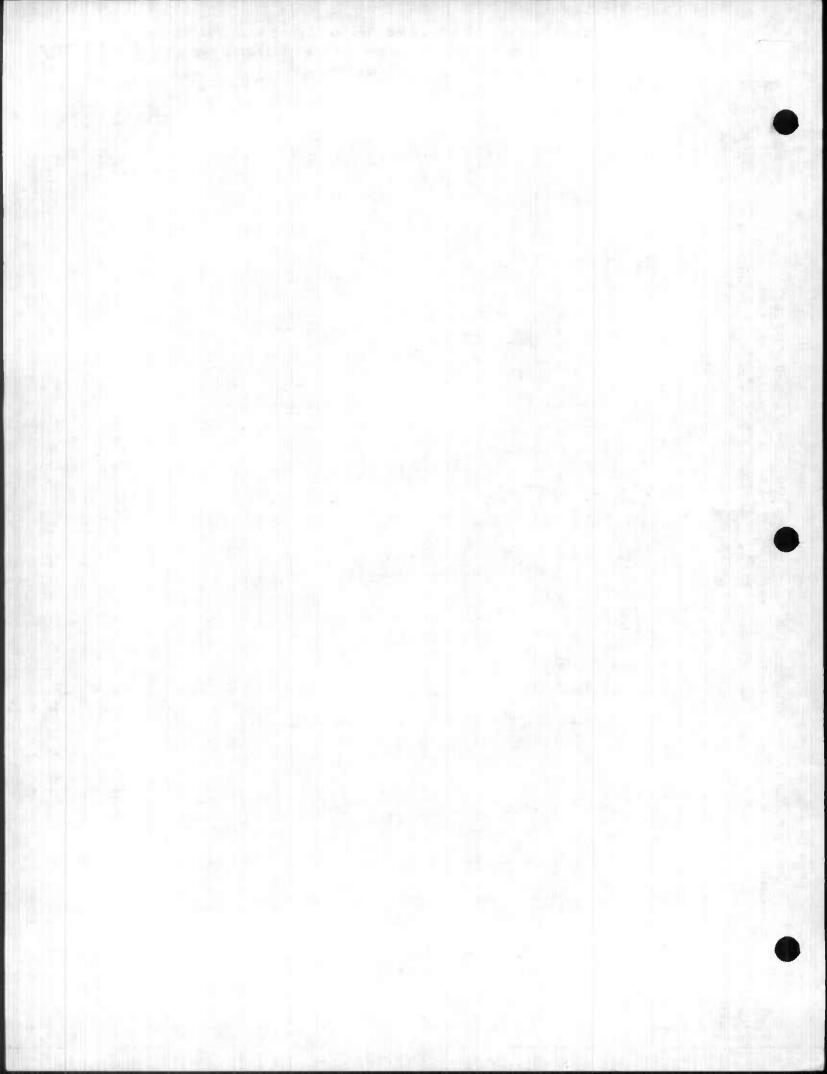
| Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of contifier 29c. License number howby D26540 March 26, 2000 30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print) Carl I. Schoenberger, M.D. 16220 Frederick Road, Gaithersburg, MD 20877 31. Dete filed (Month, Day, Year) 32. Begistrer's Signature

**DHMH 16 Rav 6/95** 

State

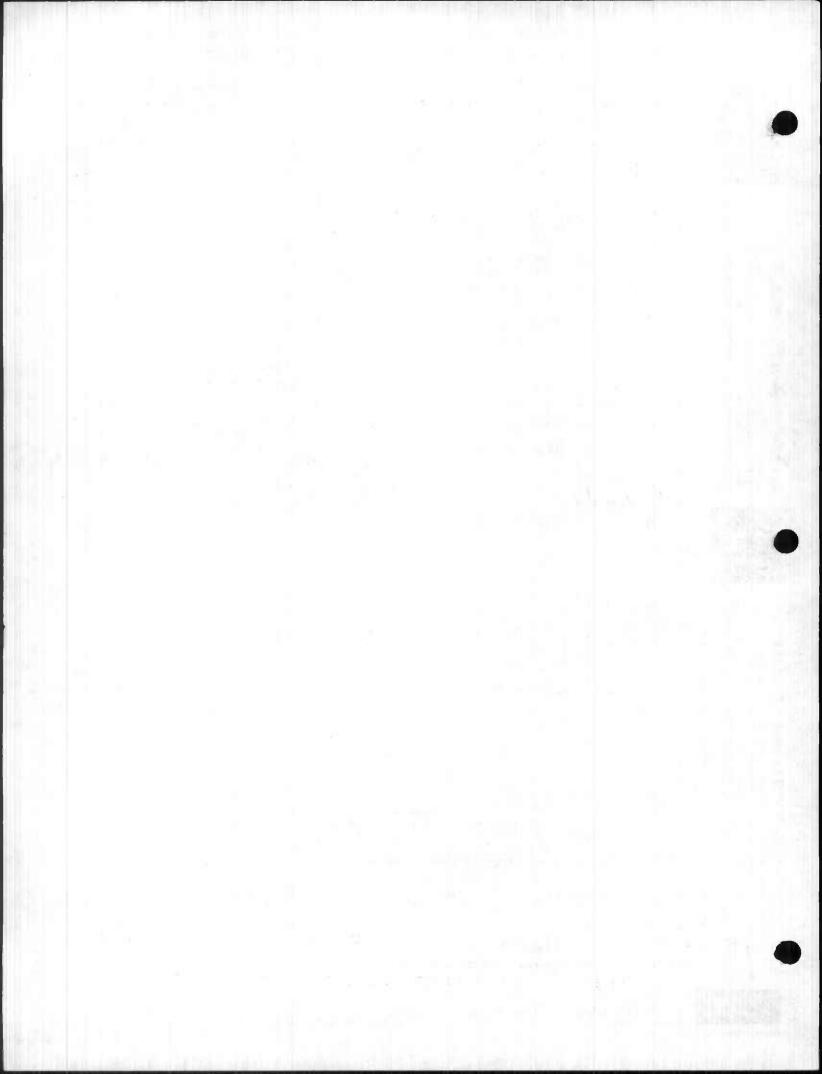
Registrar

Jenewa



State of Maryland / Department of Health and Mental Hygiene

	_					Ce	rtificate d	of Death		Reg. No.		11/0/
hysician /Medical		1. Decedent's Nam Seymo		le, Last)	Mar	golis			2. Date of Month MARCH	Dey	Yeer 00	3. Time of Deeth
xaminer		la. Fecility Neme (/	If not institution		num <i>ber)</i>			4b. City, Town, BETHE	or Location of De	ath 4c. Cou	nty of Death	CRY
neral ector	45	5. Social Security N 099.14.4	lumber	6. Sex 1 XM 2 □ F		73 Yrs.	If Under 1 Ye Months Da	ar If Under 24	Hrs. 8. Date of Min. (Month,	Date of Birth (Month, Day, Year)  EC 15, 1926  NE		piace (State or Foreign ntry) YORK
1	1	Jsual Residence of IOa. State	10b. County		10	Oc. City, Town or Lo						I 0d. Inside City Limits 1X Yes 2 □ No
be notified Director		MD i0e. Street and Nur	MONTG	OMERI		POTOMA	-	±11		I all annual		
2 5							10f. Zip Cod			10g. Citizen	of What Cou	ntry?
by Funeral		10305  1. Maritel Status  1 Never Marri  3 Widowed	ied 25 Men	ried 1 XYe	ecedent Eve Forces?	TATATT T	Was Decedent of Yes, specify C	of Hispenic Origin Juban, Mexican, P	7 (Specify Yes or uerto Ricen, etc.)	USA No- 14. F Spe	ace - Americ lack, White, city: WI	
Completed		(Spec		st grade complete	d) e (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most of tired)	working	16b. Kind of	Business/in	dustry
To Be Co	,	7. Father's Name (		Lest) MARGOLIS	3				Name (First, Midd AARONOFS		ame)	
		19a. Informant's Na HANNAH M	MARGOLI			10305	GAINSE		Rural Route Num			20854
5	2	0a. Method of Disp 1 □XBurial 2 □ 4 □ Donation	Cremation	3 □Removel from	m State	20b. Plece of Dispondencemetery, cre-	metory or other		MARCH 30, 200	20c. Locatio		own, Stete MARYLAND
4 Donation 5 Other (Specify 21 Signature of Fundral Service Licens				Licensee		2: I	2. Name and Ad EDWARD S	dress of Facility	ERAL DIF	RECTION,	INC.	
use as the bunel-trensit	Sin CO t	esulting in death)  Sequentially list cor I any, leading to im euse. Enter Undel Cause (Disease or I hel initiated events esulting in death) L		c. CONO	ONARY Due	o to (or as e consect  ARTERY D  to (or es e consect  E HEART  to (or as a consect	ISEASE (quence of): FAILURE	STATUS I	POST BYPA	ASS SURG	ERY) 1	3 YEARS AG
be deteched for unby Physician		art II. Other eignift	cant conditio	ns contributing to	death but no	ot resulting In the u	nderlying ceuse	given in Part I.		d tobacco use		the cause of death?
Completed by										es en autopsy riormed?	ev.	ere autopsy findings aliable prior to mpletion of ceuse death?
Com									10	Yes 2 No	10	Yes 2□No
director,	2	5. Wes case referrexaminer?	ed to medicel	-				26. Plece of	Death (Check only	y one)		
		1 ☐ Yes 2 ☐X1				2 ER/Outpetier	IL SLI DOM		g Home 5□Re			y)
ed in by the funeral Certification:	2	<ol> <li>Manner of Death</li> <li>Matural</li> <li>Accident</li> <li>Suicide</li> </ol>	5 Pending investig	g (Mo	e of Injury onth, Day Ye		M 1	☐ Yes 2 ☐ No		e how injury occ		
illed in by the		4  Homicide	determi	ined 286. Plac buil	ding, etc. (S				City or 7	own, Stete)		Il Route Number,
completely filled in Medical Cert	2	9a. Certifier (Check only one)	1 Certifytng 2 Medical I	examiner; On the	ne best of my basis of exa inner stated.	knowledge, death minetion and/or in	n occurred et the vestigetion, in m	time, date end pl y opinion, death o	ace, and due to th courred at the time	e ceuse(s) and e, date and place	manner as si e, and due to	ated. the cause(s)
W Com	2	9b. Signature and t	title of certifier	yen le	eam		29c. Lloe D40	970		29d. Dete sign MARCH		
5	L		M	1000								
>	30	DR. CER		V		(Item 23e) (Type, EDERICK A		THERSBUR	G, MD 2	0877		



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

29d. Data signed (Month, Day, Year)

MARCH 26, 2000

•	1. Decedent's Nama (First, Middle	a, Last)				111		2	. Data of D		14	3. Tima o	of Daath	
Physicial	The Jess Charte Me.	ssis						N	Month	25, 2	Yaar 2000	1709	PM	
/Medica Examine	A 900 1011 D.S. 1885 A.S. 171 A.S.		um <i>ber)</i>			T	4b. City, To	wn, or Loca	tion of Dea		ty of Death			
CAUTITIO	RT. 108 EAST OF	F HIPSCOY	ROAD				DAMAS	CUS		MONTG	OMERS	7		
Funeral	5. Social Security Number	6. Sex	7. Aga (In yrs. I	ast birthday)	If Undar 1	Year		24 Hrs. 8	Data of B	lirth	9. Birth	placa (Stata intry)	or Foraign	
Director	214-92-7218 Usual Residence of Decedent	₩ 2□ F	21	Yrs.	MOIIIIS	Jays	riours	IVIII.	Aug 3	1, 1978		land		
Jend **	10a. Stata 10b. County		10c. City	, Town or Lo	ocation							10d. Insida (	City Limits	
Maryler f ehow	Manual Manua		Deel	110								1 🗆 Ya	s 2 No	
deeth with the Maryland ms 23a or 28s-f show r must be notified at	Maryland Montgo	mery	KOCI	kville	10f. Zip C	oda				10g. Citizan of	What Cou	intry?		
with with	5 / 212 H	D 1			2085									
eeth w	4212 Heathfield		cedant Evar in U.	S 13		dant of Hispanic Origin? (Specify Yas or No cify Cuban, Maxican, Puarto Rican, atc.)				USA No- 14. Ba	ca - Aman	ican Indian.		
5 2 2	Maryland Montgot  10e. Street and Number  4212 Heathfield  11. Marital Status  Weer Married 2 Marria  3 Widowed 4 Divorced	Armed F	orces? 26 No Siva		If Yas, specify 1 ☐ Yas 2X			, Puarto Ri	can, atc.)	BI	ack, Whita	, atc.		
21215-0020 d within 72 hours eff glene. rr than "netural", or in Wedfall Earn	15. Decedent (Specify only highas Elementary/Secondary (0-12) 12 17. Father's Nama (First, Middle,	's Education	0	16a. Dece	dant's Usual ( kind of work DO NOT usa	Occu	pation during most	of working	16b. Kind of Busine			ndustry		
within then	Elementary/Secondary (0-12)	Collega	(1-4or 5+)				(d)			27 / 4				
122	12 17. Father's Nama (First, Middle,	( net)		Never	Worke	d	19 Moths	r's Name /	Eiret Midd	N/A la, Meiden Suma	mal			
C SEP										ia, meideri Surria	inaj			
J Menter		Nimatallah Massis Hilda Saba												
		19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
e, No leasth leasth ma 27	Hilda Marzouka/ Mother 4212 Heathfield Road, Rockville, MD 2085  20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or													
Pages mit if the my or of	1 X Burial 2 Cramation 3 Chamoval from Stata cematary, cramatory or other placa)													
lim men ment: jury	4 Donation 5 Other (Specify) Gate of Heaven Cemetery 3/29/00 Silver Spr											lng, M	D	
Baltimore, North Person 1 Pers	21. Signature of Funeral Sarvice I	Licensee	50	22 Fr	2. Nama and	Addr	Collin	ns Fi	mera	1 Home,	Inc.			
m %9529	I John !	2 au	poli							ilverSpr		MD 20	901	
	23a. Part 1. Emar tha disaasa, or shock a heart failure. List	complications that	caused tha death	. Do not an	tar tha moda	of dyi	ng, such as	cardiac or	raspiratory	arrast,	1	Approxima Interval Ba	ata	
Physician	V V	only one occou on	lications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, ne cause on each line.									Onset and		
/Medical	Immediate Causa (Final disease or condition	1	wound	26	tivi	M	158							
Examiner	rasulting in deeth)	8	a. WUT RUE THUYUSS  Due to (or as a consaquance of):											
P #		- 5												
Sox 68760, th certificate be executed the certificate be executed or use as the buriel-transit	Sequentially list conditions,	<b>7</b> 0.	Dua to (or	r as a consac	quanca of):									
e e e e e e e e e e e e e e e e e e e	Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disease or Injury that initiated events	1000									- 1			
Box 68760, she office be executively and physician and or use as the buriet-france or	that initiated events rasulting in death) Last	C	Dua to (or	as a consec	juance of):									
ndiffice addition														
Box seth certi attending for use a		d										- 100		
dee at		ns contributing to	death but not rasu	lting in tha u	indarlying cau	sa gi	van in Part f.		23b. DI	d tobacco uss o	ontributs	to the cause	of death?	
P.O. et the de t	Part II. Other significant condition								1[	Y88 2 10	3 Pr	obably 4	Unknow	
S, Post thet be delt be delt								_						
The law requires that the sale has been signed by th page 2 should be detection.									24a. Wa	as an autopsy formed?	a	Vara autopsy vailable prior omplation of f death?	to	
The la									18	as 2□No	1	Yas 2	□No	
	25. Wes casa rafarred to medical				1770		26. Pleca	of Death (						
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		28a. Date	of Injury onth, Day Year)	28b. Tima o		. Inju	ry at			e how injury occi			LIVE	
Vision Attending r death. ector: Atte by the func	1 Netural 5 Pending		oth, Day Year)	1705	W M	1	Yas 2 🖭	No 6	cen	DUNCOF	con		m Plys	
Division or Attending Patter death. Director: Attent	3 Suicide 6 Could r 4 Homicida determi	not be ined 28a. Pled	ce of Injury - At ho ding, etc. (Specify			offica		_		(Street and Nun own, Stata)			m <i>ber</i> ,	
Division Att after din by	Tomoda	DUIK	ding, etc. (Specify	mon				R	X 10	DWN, SIBIB)	Gimo	myco	- NU	

State Registrar

MAR 2 8 2000

31. Data filed (Month, Day, Year)

29b. Signatura and titla of

29e. Certifier

32. Registrar's Signatura

30. Nama and addrass of person who completed causa of daath (Itam 23e) (Type, Print)

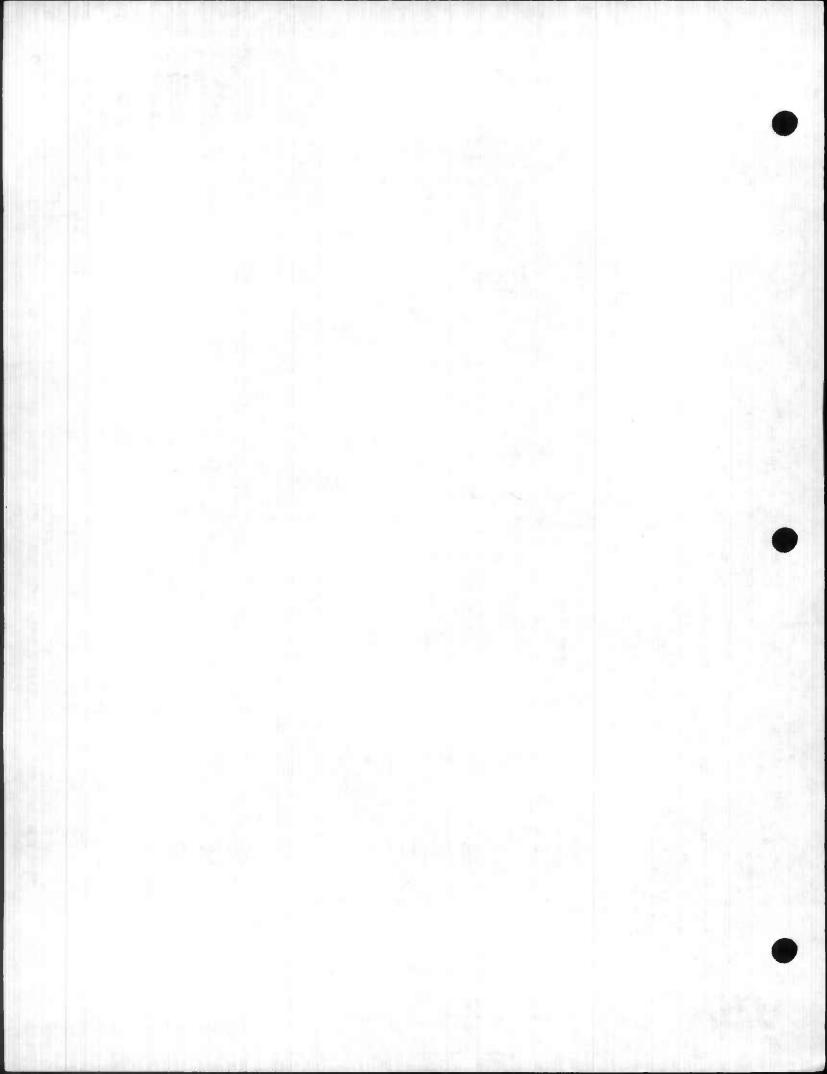
- Waw 111 Penn Street Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the causa(s) and manner as steted.

Will Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated.

29c. Licansa number

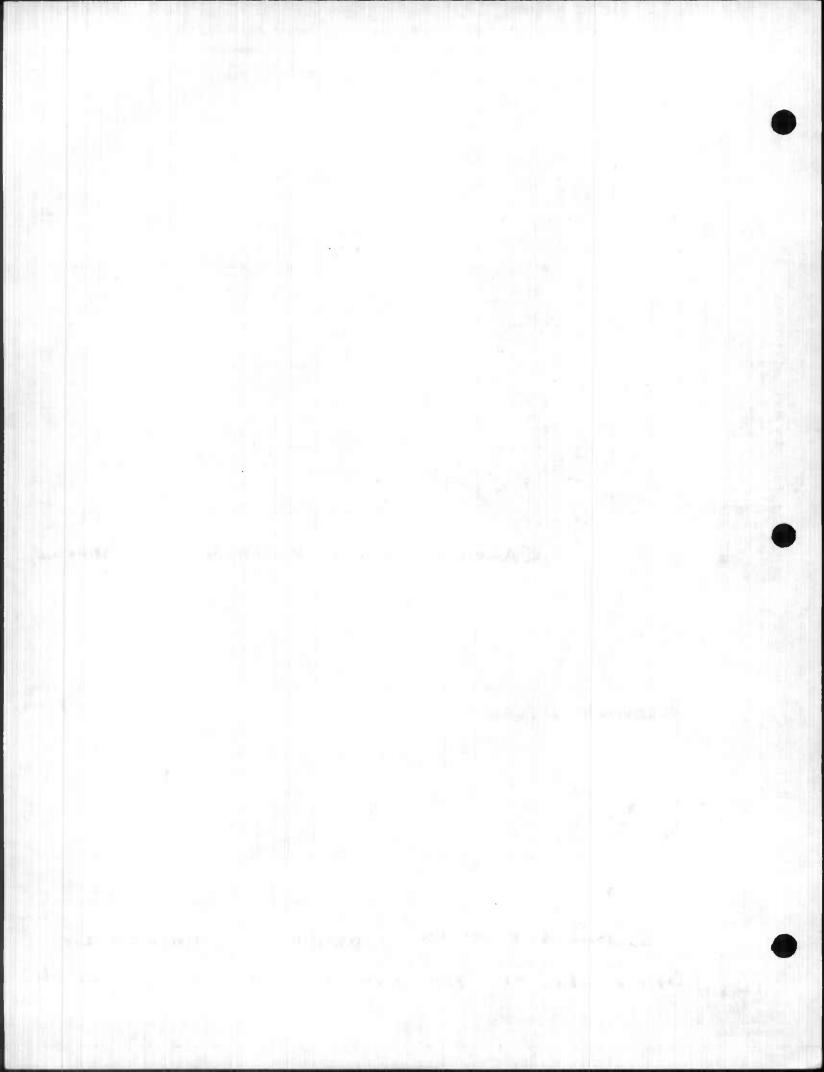
OCME



State of Maryland / Department of Health and Mental Hygiene

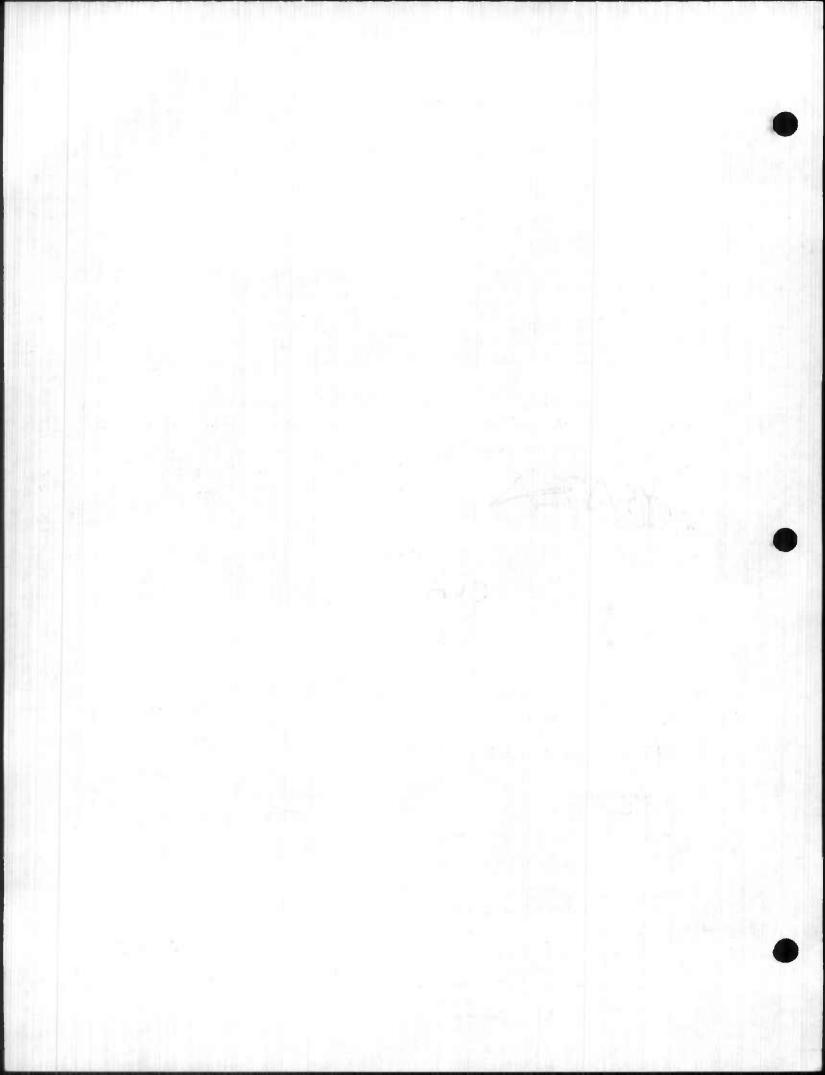
00 11789.

				Cei	rtificate of	f Death			Reg. No.	00	11103
Dhusisian	1. Decedent's Name (First, Middla,	Last)						2. Data of D Month	Death Day	Year	3. Time of Death
Physician /Medical	Marion M.	Matthew	vs - Dan	iels				March	24	2000	12:25 A
Examiner	4a Facility Nama (If not institution,	give street and nur	mber)			4b. City, To	wn, or Lo	cation of Dea	th 4c. Cou	nty of Death	h
	Holy Cross Hosp	ital				Silv	er S	pring	Mont	gomen	СУ
Funeral	5. Social Security Number	6. Sax	7. Aga (In yrs. las		If Under 1 Yea Months Days		24 Hrs. Min.	8. Data of B (Month, D	irth	Co	nplece (Steta or Foreign
Director	577-38-1817	1□M 2⊠F	75	Yrs.				Jul. 1	1, 1924	Virg	gińia
	Usual Residence of Decedant  10a. State 10b. County		100 City	Town and a	action						And Institute On Allerton
show at at				Town or Lo							10d. Inside City Limits 1 ☐ Yas 2 ☑ No
notified and		Georges	Be.	ltsvi							
al Directo	10e. Street and Number				10f. Zip Code				10g. Citizen o		untry?
	3136 Fallston A		0.00		2070				USA		
Funeral	11. Marital Status	Armed Fo	edent Ever in U,S. orcas?	. 13. }	Wes Decedent of 1 Yas, specify Cu	Hispanic Original Hispanic Origin Hispanic Origina Hispanic Origina Hispanic Origina	gin? (Spe i, Puerto I	cify Yes or N Rican, etc.)	lo- 14. R	ace - Amer lack, White	rican Indian, I, etc.
	1 Nevar Married 2 Marrie	If Yas, Gi	va.		1□ Yas 2⊠ No	o Specify:			Spe	eify: n	11-
d by	3 ☑ Widowed 4 □ Divorced	Year or D	ates:		18-197					- D	lack
Completed	15. Decedent's (Specify only highest	grada completed)		16a. Deced (Giva	tent's Usual Occi kind of work don DO NOT use retir	upation e during mosi	t of workir	ng	16b. Kind of	Business/I	ndustry
Q E	Elementary/Secondary (0-12)	College (1	1-4or 5+)	IIIa. L					Page	omah	
ပိ	1.Z		1		Biologi	_	d- 61	Wine Add to		arch	
Be	17. Fethar's Nema (First, Middla, L								e, Maiden Sum	ame)	
2	Thomas R. Matth							Motley			
	19e. Informant's Name/Ralationsh		1.5		ng Address (Street						
	Joseph Newell /	Nepnew				n Avent	ie, E				nd 20705
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation	3 □Ramoval from	con	natery, cren	sition (Nama of netory or other pi	lace)	i	Data	20c. Locatio	n - City or 1	Town, Stata
	4 Donation 5 Other (Sp.		Oak		Cemeter			31/00			irginia
SÌ.	21. Signature of Furieral Service L	censee	1/6	22	. Nama and Add	rass of Facilit	y Hir	nes-Ri	naldi F	unera	1 Home
ou /	2//	11120	1		1800 New				20904		
	23a. Part1. Entar the disaasa, or o shock, or haart laitura. List o	omplications that	ausad tha daath.							1	Approximata
an	Shock, or haart Jaliura. List o	niy one causa on a	iach lina.								Interval Between Onset and Death
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Examiner		b	5								
Exa	Sequentially list conditions, if any, leading to immediate		Dua to (or a	as a conseq	uence or):						
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edicai	resulting in death) Last		Dua to (or a	is a conseq	uerice or):						
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cia	0.4000							1 000 000	44-1		
1VS	Part It. Other algnificant condition	1		ing in that ur	noenying cause (	gwen in Part I.	•				to the cause of death?
P	ALZHEIMER'S	DISEAS	SE					11	Yes 2 N	3 U Pr	obably 4 🕅 Unknow
d b								24a Wa	s an autopsy	24b V	Ware autopsy findings
Completed by Physician								per	formed?	8	vailable prior to cause
du										-	of death?
S								1 🗆	Yas 2 No	1	I ☐ Yes 2 ☐ No
8	25. Was case rafarred to medical examinar?					26. Place	of Death	(Check only	one)		
10	1 Yas 2 No	Hospital:	Inpatiant 2 E	R/Outpatien	B ST DOA	Other: 4 Nu	irsing Hor	ma 5□Res	sidence 6 🗆 0	Othar (Spec	cify)
	27. Mannar of Death 1 ☑ Natural 5 ☐ Pending	28a. Data	of Injury th, Day Year)	8b. Tima of Injury	28c. (nj	ury at	2	28d. Describe	how injury occ	curred	
atic	2 Accidant invastiga	tion		.,,.,		Yes 2 🗆	No				
Hic	3 Sulcida 6 Could no 4 Homicida determin	ed 288. Piece	of Injury - At hom	na, farm, str	eet, factory, office	0	2	28f. Location	(Street and Nu	mber or Ru	rel Routa Number,
Cen	T I I I I I I I I I I I I I I I I I I I	Oulidi	ing, att. (Specify)					Only Or 10	, 5.6(0)		
edical Certification:	29a. Cartifiar 1 Certifying	Physician: To the	best of my knowle	edge, death	occurred et the	time, date an	d place, a	and due to the	e cause(s) and	menner as	stated.
Dig	(Check only 2 Medical E	caminer: On the ba	asis of axaminetio nar stated.	n and/or inv	astigation, in my	opinion, dea	th occurre	ed at the time	, data and place	e, and dua	to tha cause(s)
×	29b. Signatura and titla of certifiar				29c. Licer	nse number			29d. Data sig	ned (Mont/	h, Day, Year)
	Saow	wh ke	a M	5	02	4011			MARCH	127	, 2000
)	30 Name and address of necessary	ho completed so	o of death (the o	(2a) (T	21.0					_	
	30. Name and address of person w		U U 2	Saj (Type,	4 <i>CR</i>	f c.	t= 0	1.3 5	(100 0	0.	mp 2913
	SADULIAH ILA 31. Data filed (Month, Day, Year)	/ 10	egistrar's Signatu	, CA,	40137	1 301	10 1	03 /	110 CAL )	r.N	1117
State			egistrar's Signatu	4	long V.	1					
egistrar	U G ZIMIN	.000	100	10.	laborato.						



State of Maryland / Department of Health and Mental Hygiene 00 11790

				Ce	rtificate	of Death		Reg.	No.	11170
		1. Decedent's Name (First, Middle, Last)					2. Data	of Death		3. Time of Death
	Physician	Jane Blick	Meaty	yard			Marc		Day Year 2000	10:30 PM
	/Medical Examiner	4a Facility Name (If not institution, giva	street and number)			4b. City, Tov	m, or Location of		4c. County of De	
4	LAGITITIE	Genesis Spa Creek				Annap	olis		Anne Arı	inde1
	Funeral	5. Social Security Number 6. Sec	x 7. Aga (In yrs.	last birthday	) If Under 1 Y			of Birth		
	Director	252-26-2785	M 2⊠F 85	Yrs.	Months D	ays Hours	Min. (Monti Augus	t 6, 1	914 Wasi	irthplaca (Stata or Foreign Country) hington, D.C.
puel	ě u	10a. Stata 10b. County	10c. Cit	y. Town or L	ocation					10d. Inside City Limits
he Mary	or 28e-fah be notte et Director	Maryland Anne Aruno	del Ann	apolis						1 ☐ Yes 2X No
ath with t	23a or 2	10e. Street and Number 2173 Glenfield Road	đ		10f. Zip Co 2140				Citizen of What C	
d 21215-0020 filed within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f shown state Examines as inciting as letted by Funeral Director	11. Marital Status  1 Never Marriad 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Evar in U. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Datas:	,S. 13.	If Yas, specify	of Hispanic Orig Cuban, Mexican, No Specify:	in? (Specify Yas o Puerto Rican, etc	or No-	Bleck, Wh	narican Indian, nita, atc.  Thite
2 20	ted bet	15. Decedent's Edu		16a. Deca	dent's Usual O	ccupation	of warding	16b	. Kind of Businas	
21215-0020 d within 72 hours af	Hygiene. ott, 74 Hearen emt, 75 Hearen e Completed	(Specify only highast grade	Collega (1-4or 5+)		maker	one during most etired)	or working	Ow	m Home	
0	THE O	17. Father's Nama (First, Middla, Last)	4	Home	Marce	18. Mother	's Nama (First, M			
and and		John Blick				Evel	yn Yeatm	an		
Aaryle 2 should	marked marked marke	19e. Informant's Name/Ralationship (Ty	ne Print)	19h Maiti	inn Address (S		or Rural Routa N		ty or Town State	Zin Code)
Maryland of 2 should be file		Susan M. Hersman/ I								
o =	Head Per 2	20a. Mathod of Disposition			osition (Name		, Annapo		Location - City o	
Baltimore,	Department of Health a Important: if item 27 is eny injury or other tratends.	1 ☑ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Geor Chur	matory or othan	iscopal	March 2	29, Va	lley Lee,	Maryland
Ball Pemit	Import eny in	21. Signature of Funeral Service Ucense	M0068	B	2. Nama and A sethesda	ddrass of Facility 1-Chevy	Robert A Chase, In Maryland	nc. 7	557 Wisc	uneral Home/ consin Avenue
Ph	ysician	23a Pant I now the disease, or compli	cations that caused the daat		itar tha mode of	dying, such as o	ardiac or respirate	ory arrest,	7 3301	Approximata Interval Between Onset and Death
E 1	Medical kaminer	Immediata Causa (Final disaasa or condition rasulting in death)	Dev	nen	Tia			13		Yrs
L.,	- i		Dua to (o	r as a conse	quence of):					
P	neit n		, <u> </u>	4						1
death certificate be assouted	physician and s the buriel-transit edical Examiner	Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury	Dua to (o	r as a conse	quence of):					
68760, ifficete be ava	ing physicie e es the bu Medical	that initiated events rasulting in death) Last	Dua to (o	r as a consec	quence of):					
BOX	or use lor use		J							
מ מ	d lor	Part II. Other significant conditions con	tributing to death but not see	ulting in the L	indahina sauc	a nivon in Part I	226	Did tohar	co use contribu	te to the cause of death?
P. D.	signed by the ettendid be deteched for used by Physician/	Decubitus u	1 cer	oning in the c	moenying caus	a given in Fait i.	230.			Probably 4 Unknown
of Vitai Records, Physicien: The lew requires t	shoul ete	Hip abs	'ce55		14		24a.	Wes an ai		Wara autopsy lindings eveilable prior to completion of cause of death?
T A	certificate has rector, page 2 Be Comp							1 🗆 Yas	2 1 No	1 ☐ Yas 2 ☐ No
= ==	ertifica octor, Be C	25. Was casa rafarred to medical				26. Place	of Death (Check of	only one)		
OT VITA	his certific if director, To Be	axaminar?	lospital:	ER/Outpatie	nt 3 DOA	Other			8 Other (Sp	pecify)
Ono deng Ph	= e	27. Manner of Death 1 Naturel 5 Panding 2 Accidant invastigation	28a. Data of tnjury (Month, Day Year)	28b. Time o	of 28c.	Injury at Work? 1 Yes 2 N	28d. Desc	-	njury occurred	
> ×	within 24 hours after death. To the Funeral Director: Affert completely filled in by the funer. Medical Certification:	3 Suicida 6 Could not be 4 Homicida detarmined	28a. Plece of Injury - At ho building, atc. (Specify		reet, factory, of		28f. Locat	ion (Stree or Town, S		Rural Routa Number,
Ne Hospital	within 24 hours a To the Funeral C completely filled Medical Ce	29a. Cartifiar (Check only one) 1 Certifying Physical Check only one)	ilclan: To the best of my kno- ner: On the basis of examinal and mannar state.	wledga, deat tion and/or in	th occurred at the action, in	ne tima, data and my opinion, deatl	place, and dua to n occurred at tha t	tha cause ime, data	e(s) and mannar and place, and di	as stated. ua to the cause(s)
To the	To the comp	29b. Signeture end title of cartifiar	/		29c. Li	cense number		29d.	Data signed (Mor	nth, Day, Year)
	vo	) Joseph 9) }	- news		D	1796	5	3	127/0	00
		30. Name and address of person who co	mplated causa of daath (Itag	23a) (Type,	Print) R	lacky F	tre 1	Bnn	goolis.	mol 21401
	State	31. Data filed (Month, Day, Year)	32. Registrar's Signa	tura	- /					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Meissner Sr. 755 Edward March Richard 27,2000 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Sundy Springs Brooke Grove Muntgonery NUSSING (enter If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months 100 M 2□ F 220-38-110 Yrs. Director October 17, 1910 Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow r 28a-f ehow 1 ☐ Yes 2 No Director Maryland | Montgomery 01ney 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "naturel", or items 23s or traumatic event, its Medical Examiner must be 4108 Charley Forest Street 20832 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours aftar 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☒ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumails exercise. Elementary/Secondery (0-12) College (1-4or 5+) 12 Policeman Law Enforcement 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) P Herman Meissner Augusta Shults 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Bessie B. Meissner / Wife 4108 Charley Forest Street, Olney, MD 20832 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Dete 1 ☐ Buriei 2 M Cremetion 3 ☐ Removel from State Mar 29 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 2000 Alexandria, VA 21. Signeture of Bunerai Service Licensee 22. Name end Address of Fecility Collins Funeral Home, Inc. o au 500 University Blvd, West, Silver Spring, MD 20901 23e. Port1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Cerebrovascular accident seven days diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner atrial fibrillation requires that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) P.O. Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t preumonia Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed demention 1 ☐ Yes 2 DXNo 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturet 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🌠 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

MID.

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

M.D.

18111 Prince

32. Registrer's Signeture

David Plotkin

MAR 2 9 2000

31. Dete filed (Month, Day, Year)

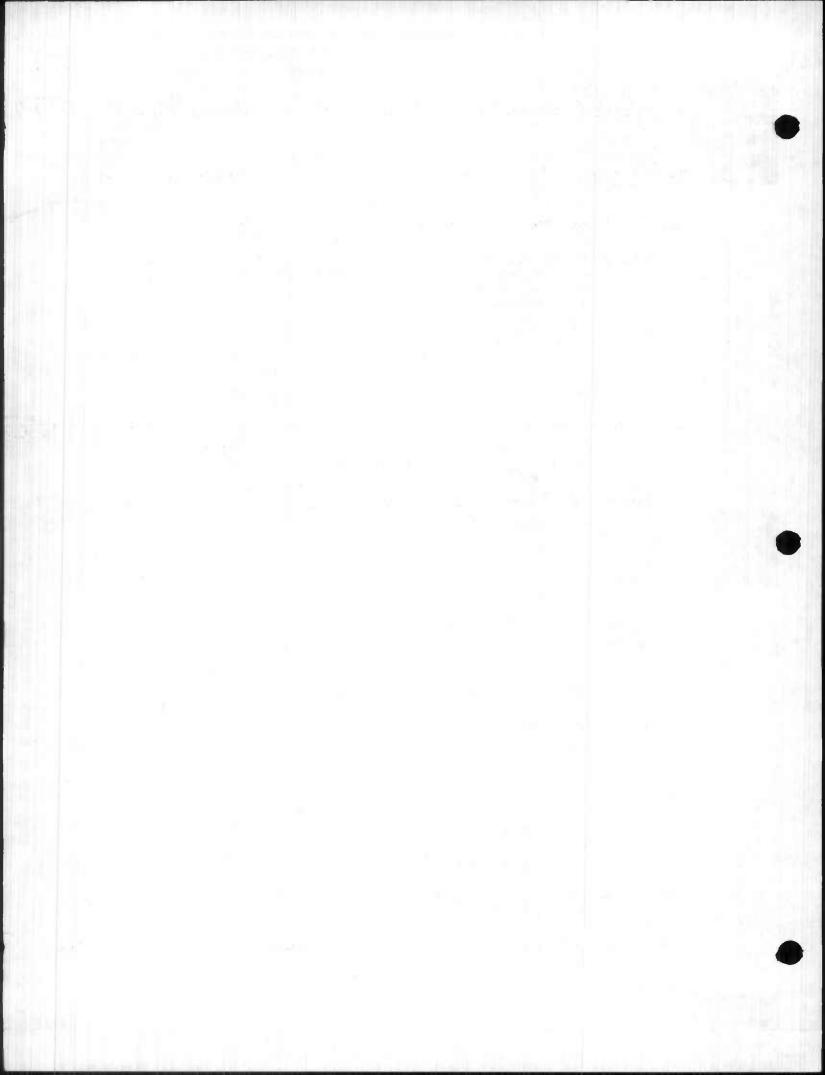
D52481

March 27, 2000

Philip Drive, suite 304, Olivey May had 20832

State Registrar

30



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month March 23, Rov Monroe 2000 12:40 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Months Days Hours 1 M 2 □ F 217-66-4008 42 Maryland October 1.1957 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Odenton 1 ☐ Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1818 Goldsborough Lane 21113 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cabinet Maker Self-Employed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Monroe (Unknown) Jane 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monroe/ Wife 1818 Goldsborough Lane Odenton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Chesapeake Crematory, INC 3/24/00 4 Donetion 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 9 8717 Green Pastures Drive Baltimore, MD Xamo 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on sech line. Approximate Intervat Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) ens Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Mother (Specify) HOSpice Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner The law requires that the death certificate be executed the burial-transit Physician/Medical Records, P. s certificate has been signed director, page 2 should be de py Be Completed 3000 Viital or Attending Physician: Medical Certification: To jo this no After death. within 24 hours after deatl To the Funeral Director: filled in by

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

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re 23s or

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Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiens.

Hygiena.

. if them 27 is

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of pertifies

Riley

29c. License number mo

29d. Date signed (Month, Day, Year)

State Registrar

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture MAR 28

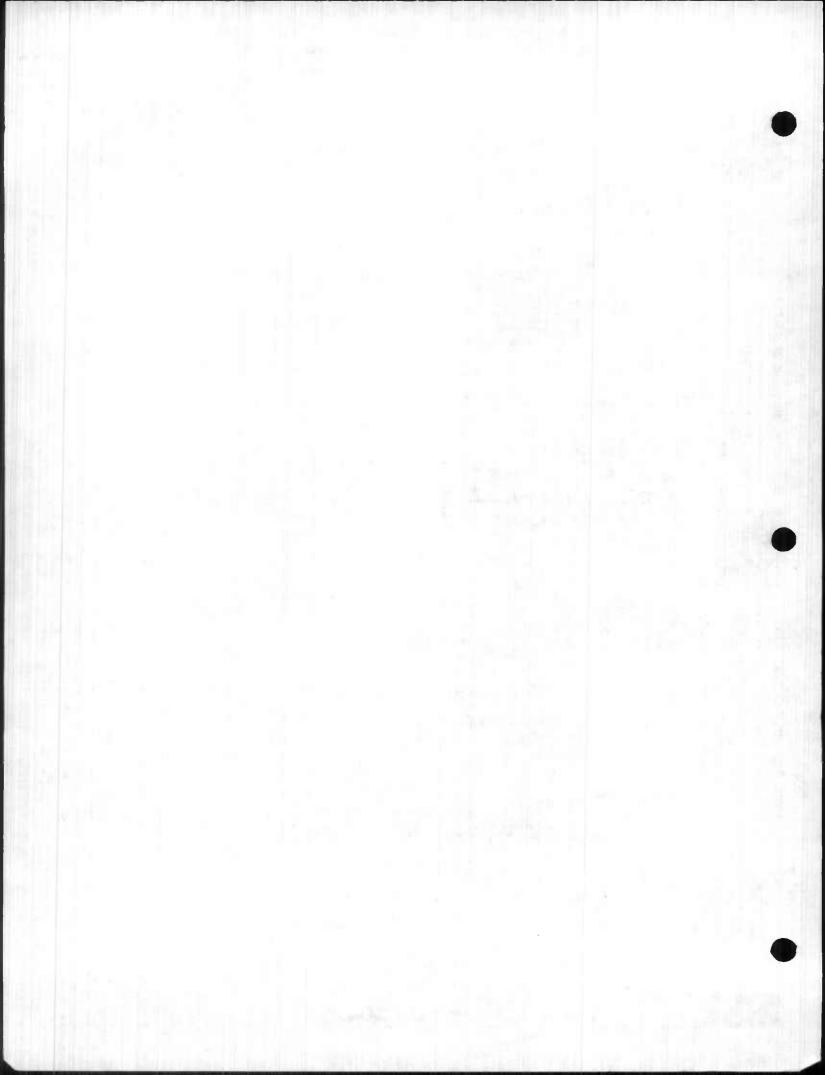
N. Charles St. Balto. Md 21204 6700

use of death (Item 23a) (Type, Print)

Hospital

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** Elizabeth March 27, 2000 9:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11328 Mitscher Street Kensington Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days Hours Months Yrs Director 244-38-6548 75 North Carolina Jan. 11, 1925 Usuet Residence of Decedent the Maryland 10a Stele 10b. County 10c. City, Town or Location than "natural", or items 23a or 28a-f show the Wedical Everymer must be nothed at 10d. Inside City Limits 1 ☐ Yes 21X No Directo Maryland Montgomery Kensington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11328 Mitscher Street 20895 United States Funeral 12. Was Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2K No Specify: by 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any Injury or other traumatic event, tha I brites. 5+ Artist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Martha Pringle George Loy Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Christeen O'Connell 5723 Crestridge Court, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 3/28/00 Alexandria, Virginia 22. Name and Address of Fecility DeVol Funeral Home 10 East Deer Park Drive 21. Signature of Funeral Service Licensee obert Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) a Carcinoma Of The Esophagus l Year Examine Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1K Yes 2 No 3 Probably 4 Unknown signed l Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☑ Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27, Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No death. investigation To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. one! 296. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30 March 28, 2000 INTER DENE LOCKUME MI

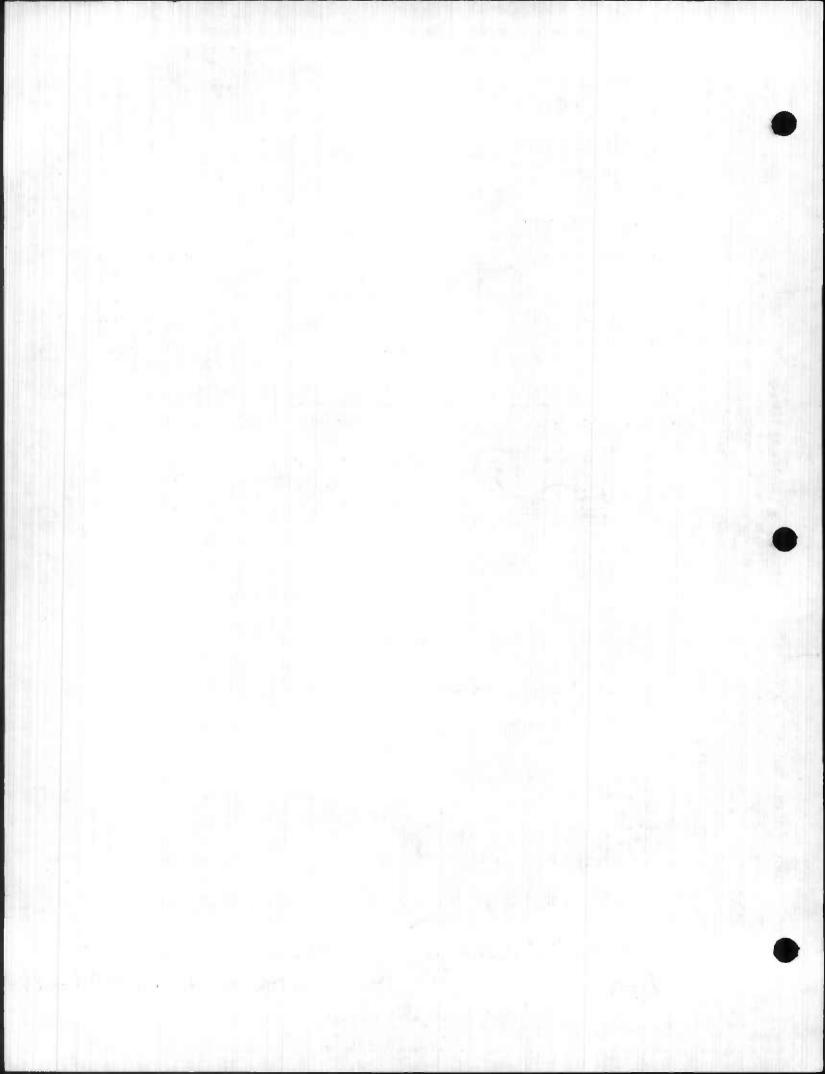
State Registrar

31. Date filed (Month, Dey, Year)

MAR 29

32. Pagistrar's Signeture

2000



State of Maryland / Department of Health and Mental Hygiene

11794

						Cer	lillcale	UI	Death			Reg. N	lo.			
Observatoria		1. Decedent's Ner	me (First, Middla, L	ast)							2. Date of		ey	Year	3. Tim	e of Death
Physicia /Medic	_	Jeremiah	n K. Muka	sa								19,	-		6:1	Rom
Examin	_	4a. Facility Name	(If not institution, go	iva street and nu	umber)		-	4	b. City, To				c. County			) Pitt
		Holy Cr	coss Hosp	ital					Silve	r Sp	ring	Mo	ntgo	merv		
Funeral Director		5. Social Security N/A		Sex 1∭ M 2□ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Months		If Under Hours	24 Hrs. Min.	8. Date of	f Birth Day, Yaa 8, 20	r)		olace (Stantry)	ta or Foraigi
		Usual Residence										-,				
show ad at	_	10a. State	10b. County		10c. Ci	ity, Town or Lo	cation							1		e City Limits
28a-f sh nottined	Director	MD	Montgo	mery	S	ilver S	pring								1 🗆	res 2∏ No
o g	Dire	10e. Street and Nu					10f. Zip C	Code				10g. C	itizen of V	What Cour	ntry?	
ner must s	<u>ra</u>	10100 Ne	w Hampsh	ire Aver	nue #105	5	209	903				U	SA			
MAIORDINE IN	by Funeral		rried 2 Married	Armed F	2√ No ive	i	Was Decede f Yes, specif 1 ☐ Yes 2]	fy Cuba	ispanic Ori in, Mexicar Specify	gin? (Spi i, Puerto	ecify Yes o Rican, etc.	r No- )	Blac	e - Americk, White,	etc.	1,
disal Exa			15. Decedent's E		Ja163.	16a Decad	dent's Usual	Occup	ation			16b	Kind of Bu	ısiness/în	dustry	
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me M	Completed	Elementary/Sec N/A		College (	(1-4or 5+)		/A						7.T	/A		
event,	Be C	17. Father's Name	e (First, Middla, Las	st)		14	1 47		18. Mothe	r's Name	(First, Mi	ddla, Maida		,		
	ToB	Stephen 1	Mukasa						Ju 1 -	et i	Bamut	W.O.				
traumatic	-	19a. Informant's N	Name/Relationship	(Type, Print)		19b. Mallin	ng Address (	Street					or Town	State. Zir.	Code)	
Important: If Item 27 It any Injury or other tre once.		20a. Method of Dis 1 X Burial 2 4 Donetion	Mukasa - sposition  Cremation 3 [ 5 Other (Spec	Removal from	01-1-	camatary, cren	leaven	ner plac Ce	meter	у 3	/27/0	0 Sil	ver :	Sprin	own, Stat	ID
9 6 6 9				110		Ran	. Name and	Addre	s or racillo	y		C		0 . 1	-	
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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Yaar)

MAR 2 8 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

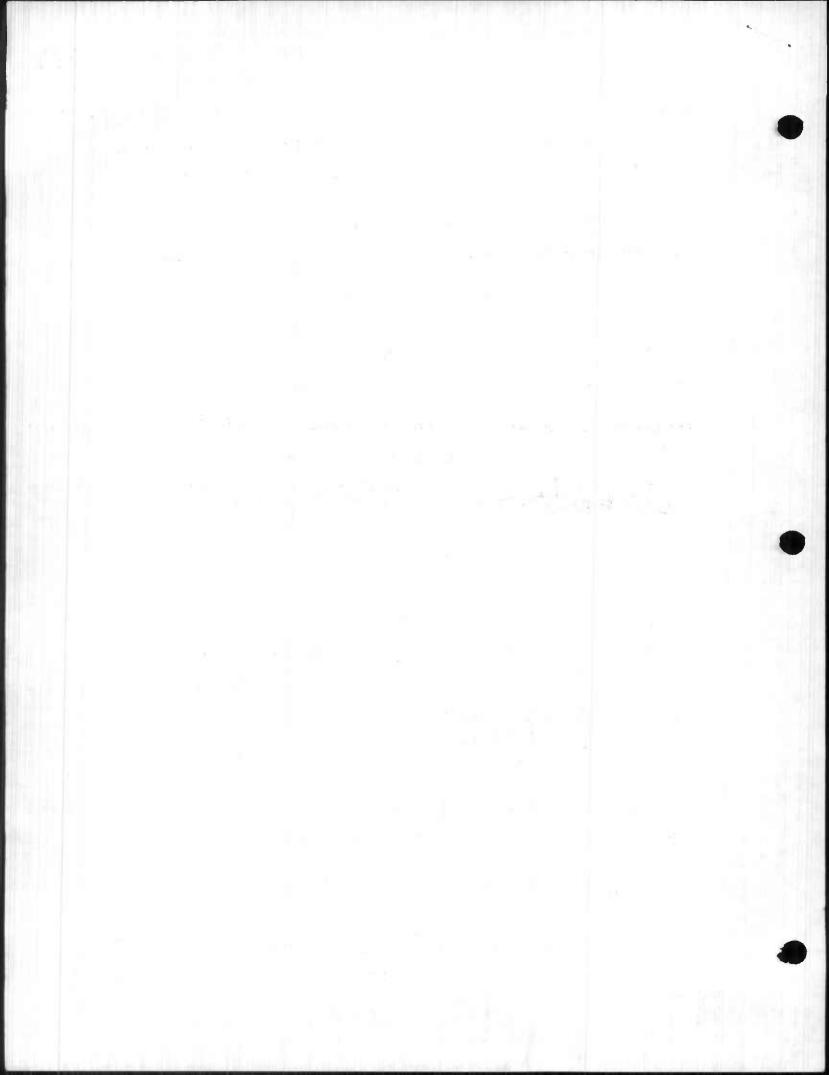
Sharon C. Kiernan, mD 1500 Forest Glen Rd. Silver Spring, mD 20910

29c. License number

D0046711

29d. Date signed (Month, Day, Year)

3/20/00



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 95 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death Day Month Yaar ROBERT McPHERSON, SR. KEVIN 29 2000 9:38 AM March 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death La Plata If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) — Min. Min. (Month, Day, Year) — mber 19, 1935 Charles Civista Medical Center 9. Birthplaca (Stata or Foreign Country) 5 Maryland If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Days Months 215-38-9235 Yrs. 64 Usual Residence of Decedent 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7064 Herbert Road 20637 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Hair 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Henry McPherson Emily Ruth Summers McPherson 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose McPherson/Wife 7064 Herbert Rd. Hughesville, MD 20637 20b. Place of Disposition (Name of cemetery, cremetory or other place) St. Mary 's 20a. Method of Disposition 1 X Burlal 2 □ Cramation 3 □ Ramoval from Stata 20c. Location - City or Town, Stata 4/1/00 Bryantown, MD. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility M00945 BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 CHARLOTTE HALL, MD. April Shock, or heart failure. List only one cause on each line. 20622 Interval Between Onsal and Death Immediate Cause (Final disease or condition resulting in death) Que to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enler Undarlying Causa (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ■Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yas 2 No 1 Yes 2 No 28. Place of Death (Check only one)

Physician /Medical Examine

Department of Important: If it any injury or o

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If item 27 Is marked other than "natural", or items 23s or 23s-f ahow arry or other than "natural", or interest and any or other traumatic event, in Mental Exerting must be notified.

physician end s the buriel-transit 80 attending esn for ed by the a signed by t should t certificate has b director, page 2 s director, this After death.

The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

To the within 2

24 hours after Funeral Direction by letely filled in b

completely

after Hospital

Examiner Physician/Medical Certification:

funeral Director: A

by Completed Be 10

edical

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Mannet of Deeth 1 PNatural

(Check only one)

5 Pending investigation 2 Accident

6 Could not be determined 3 Sulcida 4 Homicide 29a. Certifier

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner staled. 29c. License number 29d. Date signed (Month, Day, Year)

29/00

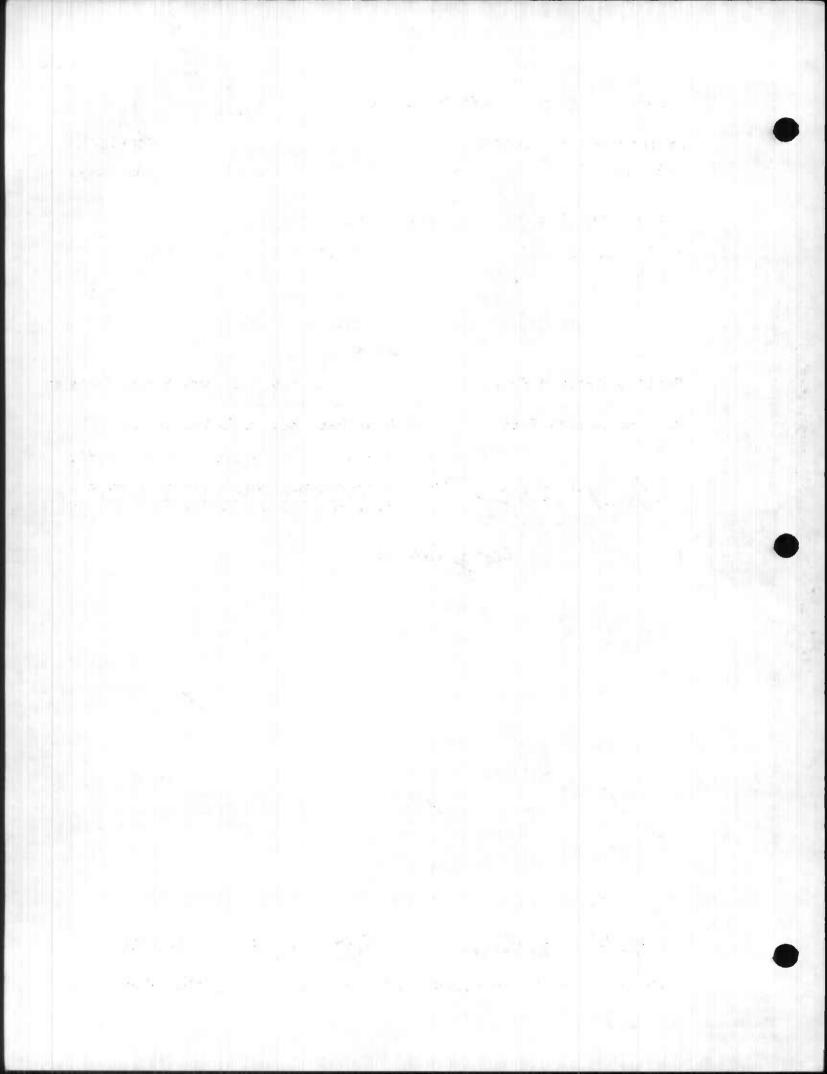
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

249 Waldorf, MD. 20604 P.O. Box Michael A. Leatherwood, M.D. 31. Date filed (Month, Day, Year)

State Registrar

MAR 3 1 2000





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Helen Makoff March 27 27, 2000 4c. County of Deeth 5:10 pm /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Stimos F If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Centry Carl If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 89 Months Daya 416-09-5483 Director Sept 6, 1910 Tennessee Usual Residence of Decedent 10b. County 10e. State 10c. City, Town or Location an "natural", or flams 23a or 28a-f show Madical Examiner must be notified at 10d. Inside City Limits Baltimore Catonsville Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 707 Maiden Choice Lane 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Procurement Technician U.S. Air Force permit. Pagas 1 and 2 should be filed Dapartment of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumeme) Be Henry Ibos Marie Lance 19a. Informant'a Name/Relationable (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. R. Brian Makoff (Son) 1758 Willow Springs Drive, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 💢 Other (Specify) Entombment 3/29/2000 Marriottsville, MD Crestlawn Mausoleum 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Sykesville, MD 21784 (410)-795-1400 shock, or heart feilure. List only one cause on each line. nterval Between Onset end Death **Physician** /Medical End Stage Congestive Heart failure Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown à 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 Yes 2 No 25. Wes case referred to medical Be 28. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA Other: Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Medical Certification: 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records. Vame.

sician and burial-transit cartificata Aftar this i or Attending Fatter death. Director: To the Hospital
within 24 hours a
To the Funeral C

the Maryland

filed within 72 hours aftar

then

Baltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year) State

29a. Certifier

10 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Year)

29b. Signeture and title of certifier

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

51051

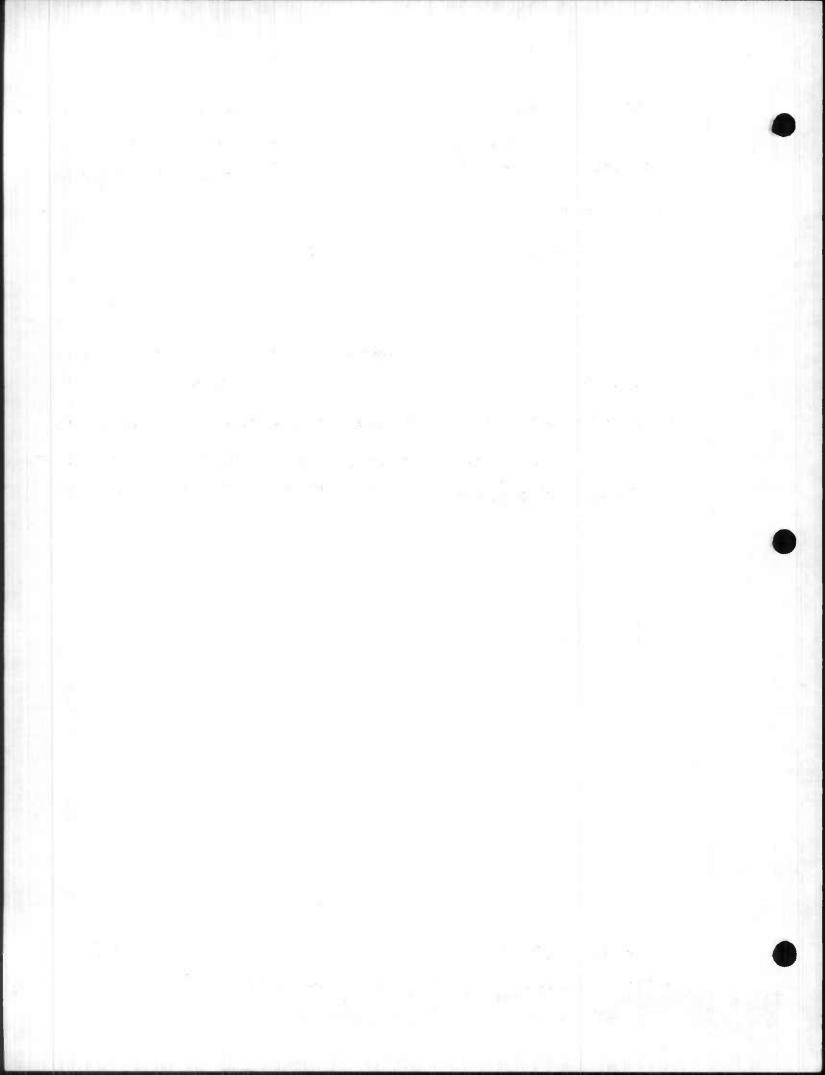
Andres

MAR 2 9 2000

Maiden Choice Lane, Catinsville, MD, 21228 Salazar 32. Registrar's Signature

DHMH 16 Ray 6/95

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Betty Merritt March 26 2000 7:12pm 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Continuum Care at Sykesville Sykesville Carroll If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Hours 216-34-5968 1 M 2 TF 62 Yrs. May 7, 1937 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Md Sykesville 1 TWes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? Race - American Indien, Bleck, White, etc. 11. Maritei Status 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) waitress food service 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Calvin Henry Jr. Elizabeth Robbins 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3711 Dorchester Rd. Baltimore, Md 21215 Geraldine Henry (sister in law) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State Springfield Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 3-28-2000 Sykesville, Md 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Haight Funeral Home & Chapel Paige Haight Derbert P.O. Box 195 Sykesville, Md 21784 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or as e consequence of): 6 W Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ne 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? N.B. 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

Be

**Funeral** 

Director

"natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygen importants if them 27 is marrised other than any Injury or other trauments.

72 hours sher

Baltimore, Maryland 21215-0020

Box 68760

Division

Examine Physician/Medical

attending physicien end for use es the burial-transit thet the death certificate be of Vital Records, P.O. page 2 s certificate has s after death.

I Director: After this or
of in by the funeral dire Certification: To Hospital or Attending To the Hospital within 24 hours o To the Funeral I

by Completed Be

27. Menner of Death

29a. Certifier (Check only

1 Naturel 2 Accident 3 Suicide 4 Homicide

5 Pending Investigation 6 Could not be

28e. Dete of Injury (Month, Day Year)

28b. Time of tnjury

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signeture and title of certifier

29c. License number

1 Destitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Robert Kroopnick

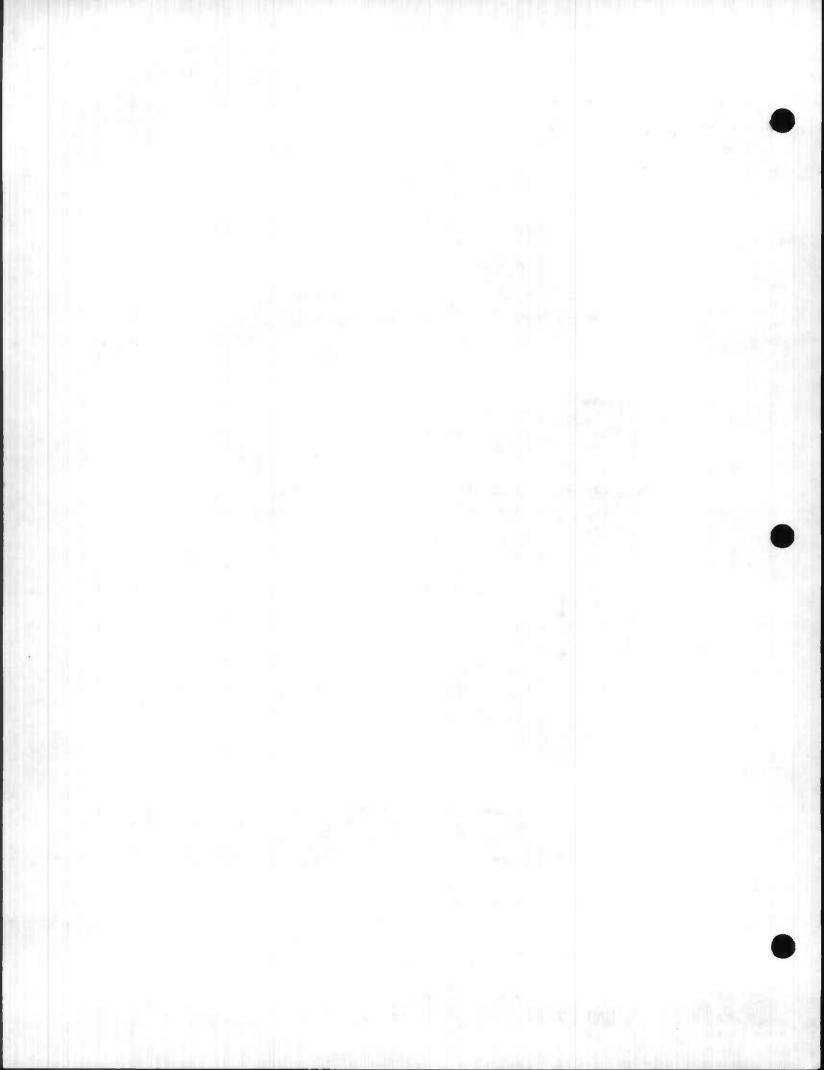
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State Registrar

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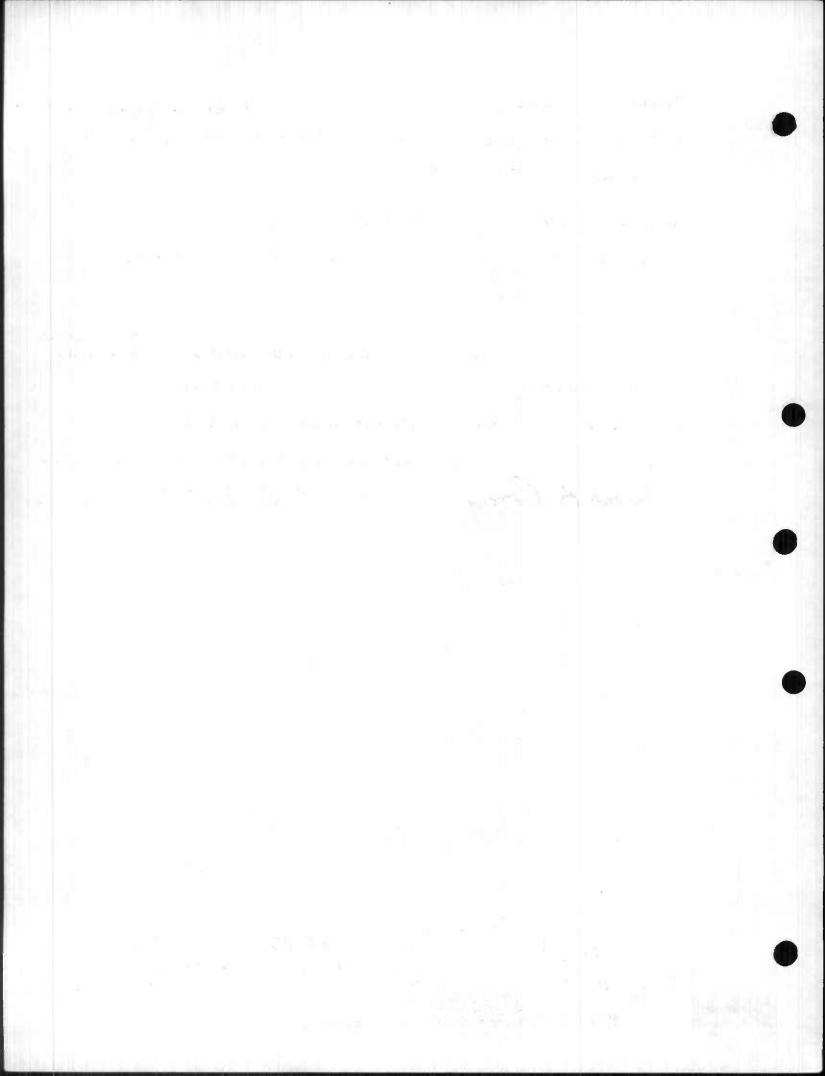
31. Date filed (Month, Dey, Year)

32. Registrer's Signeture



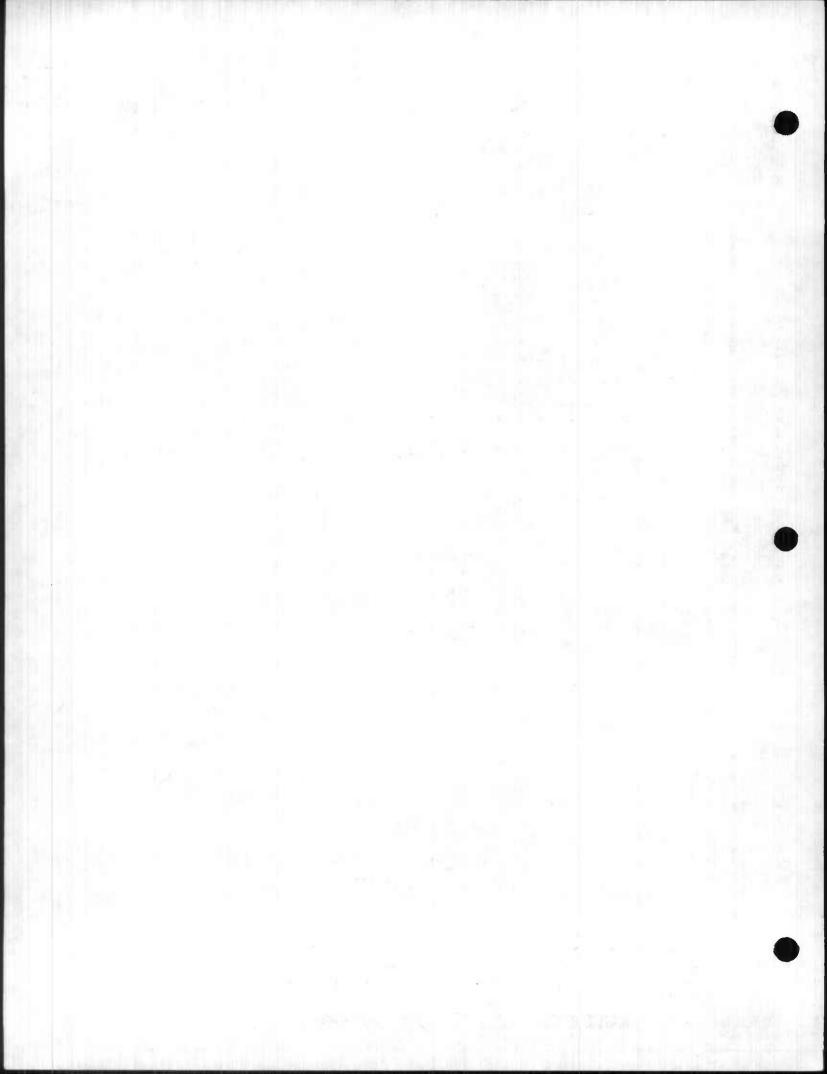
State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** DONNA Month 27 H MACLEAN 3:58 Pm MARCH 2000 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE CENTER. RAMPAUSTOWN MORTHWEST HOSPITAL 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Hours 1 M 2 N F 79 Yrs Director Iowa 480-18-2495 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 N No ms 23a or 25e-f a must be notified Director Maryland Baltimore Pikesville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21208 926 Adana Road Funeral United States than "natural", or llems the Medical Examiner m 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus Pages 1 and 2 should be filled within 72 hours after vant of Health and Martal Hygiens.
Int: If Item 27 is marked other than "natural", or les 1 Never Merried 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Yeer or Detes: Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3₺ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena, other than Bureau of Hearings Elementery/Secondary (0-12) Collega (1-4or 5+) and appeals Social Security Administration 2 years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 88 Nina Thompson Daniel Walsh Booth 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If them 27 is any Injury or other traces once. 305 Kennard Ave. Edgewood, MD 21040 Douglas D. MacLean Son Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete All County Cremation, Inc. 3/29/2000 Sykesville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Name end Address of Facility Burrier-Queen Funeral Directors, P.A. amen vens MD 21784 1212 W. Old Liberty Road Sykesville, Part. Enter the disease, or complications that can's disease, or heart teilure. List only one cause on facy line. Approximete Intarval Batween Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medicai SEPSIS Examiner Due to (or as e consequence of): Examiner OSTEOMYELITIS the death certificate be executed physician end s the burief-trans Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 88 nse 10 ed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BREAST CANCER. signed I þ 24b. Ware autopsy tindings aveilable prior to completion of ceuse of death? Completed 24a. Was en eutopsy performed? CARDIOMYOPATHY. ESTRICTIVE s certificate has b director, page 2 s 1 Yes 2 KNo 1 ☐ Yes 2 KNo Division of Vital 25. Wes case referred to medical examiner?

1 Yes 2 No funeral director 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27, Menner of Death 28d. Describe how Injury occurred 28b. Time of 28a. Dete of tnjury (Month, Day Year) 28c. Injury at Work? After 1 Neturei 5 Pending investigation or Attending after death. Director: After 1 ☐ Yes 2 ☐ No 2 Accident 部 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) á 4 Homicide Hospital 24 hours Funeral 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred et tha time, dete end plece, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) within 2. 29c. License number 29b. Signeture and little of certifier PHISICIAN. 29d. Dete signed (Month, Day, Year) 242723. annn 2000 NORTHWEST CENTER. 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) HOSPITAL AYVERAHALLI FIARISH RANDALLSTOWN 31. Dete flied (Month, Day, Year) 32. Registrar's Signature State Sporks Registrar MAR 2 9 2000



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

799 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** Hazel Myers 10.15 PM Loretta March 26th 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country)
 A A 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Days Hours 215-20-8400 Yrs. Director Feb 13 1926 Usual Residence of Decedent the Marviand 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits man be notified at Md Carroll Sykesville 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6304 Freedom Avenue 21784 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. r than "naturel", or flame the Medical Examiner ma 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours effer Hygiene. Wher then "naturel", or the 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) beautician cosmetology . Pages 1 and 2 should be filled w transt of Health and Mentel Hygier tant: If Nem 27 is marked other th jury or other traumatic event, the altimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Harry Raymond Duvall Julia Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Mr. Robert W. Myers (spouse) 6304 Freedom Ave., Sykesville, Md 21784 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata Data 20a. Mathod of Disposition cematary, crematory or other place) 1 Burial 2 Cremation 3 Removal from Stata permit. Page Department of Important: If eny injury or page. Trinity Lutheran Cem. 3-30-2000 Westminster, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Servica Licenses Paige Harght Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Finat /Medical Pneumonia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Anemia The lew requires that the death certificate be executed physicien and the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Myelo mono cytic leukemia Box 68760. Chronic Physician/Medical Due to (or as a consequence of) for USB BS signed by the e P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has page 2 2 No 1 ☐ Yas No 1 Yes or Attending Physician: 89 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospitat: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2N No this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Naturat after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated. completely (Check only 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 943 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Home officer Lina Cloerms 038993 3126100 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) ImanCldo Westminster Maryland Memorial 200 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar MAR 2 8 2000

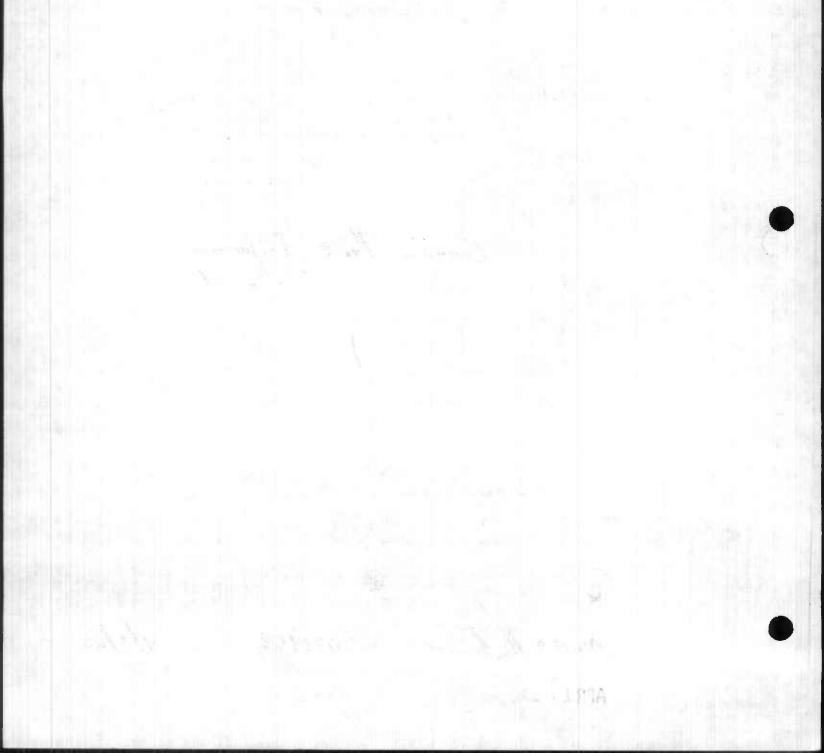


State of Maryland / Department of Health and Mental Hygiene  Certificate of Death	00	- 1
Certificate of Death Reg. No.	00	

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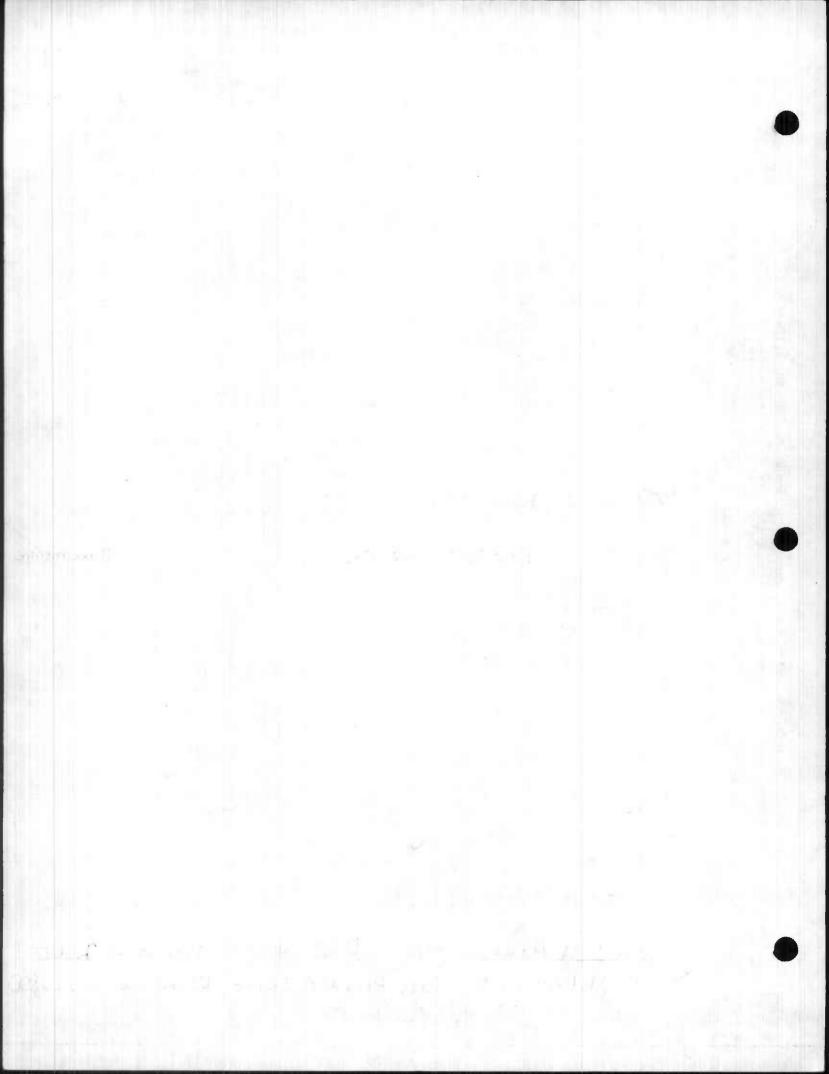


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name /First Middle Last 2 Date of Death **Physician** March 2000 5:45 P. M. Rita Ne 1 son Ann /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Baffin Bay Court Montgomery If Under 1 Year | If Under 24 Hrs. | Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□M 2\ F Vrs 577-56-9469 Director 58 Nov. 30, 1941 Washington, DC. Usuat Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits "natural", or frame 23s or 28s-f show of call Examiner must be notified at 1 ☐ Yas 2 🖾 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 눔 with permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 234 any injury or other treumatic event, the Made at Examinar must any injury or other treumatic event, the Made at Examinar must ponce. 6 Baffin Bay Court 20853 U.S.A.

14. Race - American Indian,
Black, Whita, atc. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Narried Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Lerner Corporation 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) 8 2 Russell Barbour Margaret Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Michael E. Nelson 6 Baffin Bay Court, Rockville, Md. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 3/29/2000 Silver Spring, Md. 22. Nama and Addrass of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses Hombaker 5130 Wisc. Ave. NW., Washington, D.C. 20016 homa 23 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical BREAST CANCER Three months Examiner Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, by cate has been sig. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yas No 1 □ Yes 2 □ No certificate Division of Vitai or Attending Physician: director, 89 25. Was case referred to medical 26. Placa of Death (Check only ona) axaminer?
1 Yes 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation After Natural 1 ☐ Yes 2 ☐ No death. 2 Accident ne Hospital or Attendi n 24 hours after death ne Funerel Director: / pletely filled in by the f 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as stated.

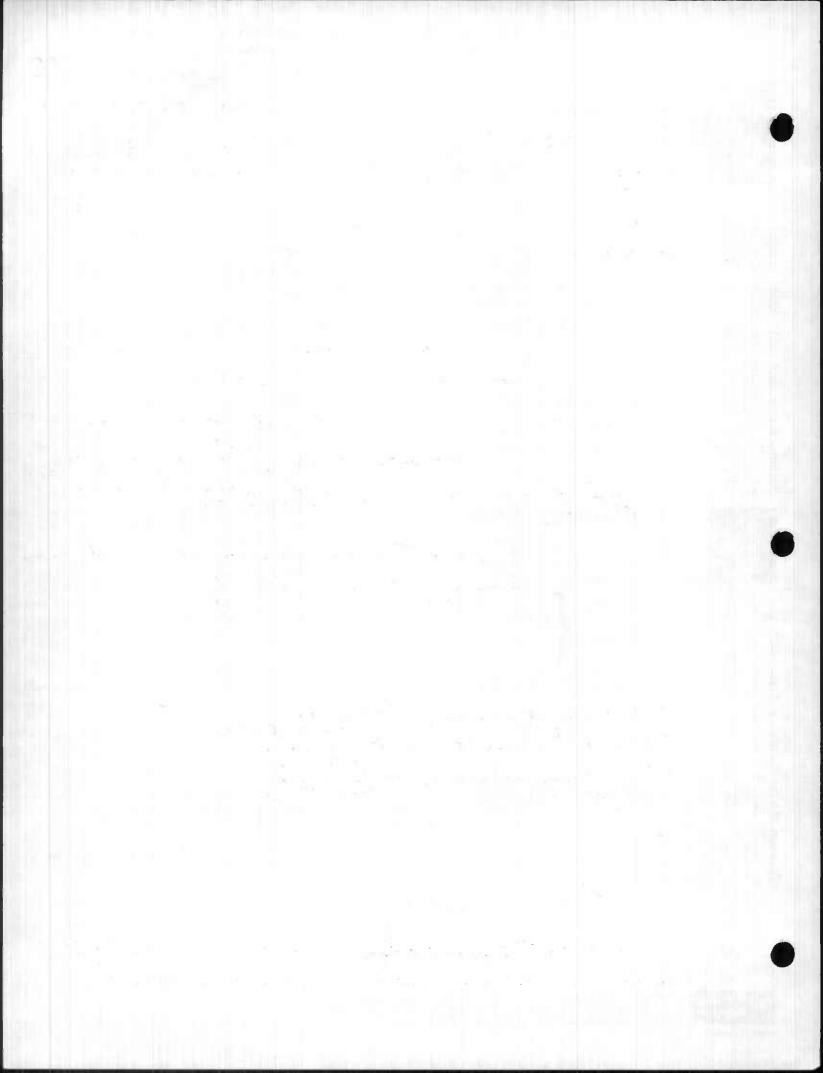
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) and manner stated. 29a. Cartifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12 March 27,2000 MMM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 PICCARD DRIVE, ROCKVILLE, MD 20850 M. HANNON, MO 31. Data filed (Month, Day, Yaar) 32. Aegistrar's Signature State MAR 28 2000 Registrar

DHMH 16 Rev 6/95



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Oldio Ol II	naiyiana / L	Certificate of		F	leg. No.	) 11802
		1. Decedent's Nama (First, Midd	la, Last)				2. Data of Dea	th	3. Tima of Death
H	Physician	Dorothy G. N	olan				Month March		7ear 100 5:45 PM
	/Medical  • Examiner	4a Fecility Nema (If not institution		or)		4b. City, Town, or I	Location of Death		
A		Wilson Healt	h Care			Gaithers	burg	Monte	gomery
	Funeral Director	5. Social Security Number 017-01-3655		Aga (In yrs. last bii 86	thday) If Undar 1 Yea Months Days	r If Undar 24 Hrs.	8. Data of Birth (Month, Day April 19	Year) , 1913	9. Birthplace (Stata or Foreign Country) New York
	pud *	Usual Rasidance of Decedent  10e. Stata 10b. County	,	10c. City, Tow	n or Location				10d. Inside City Limits
	fanyle fanyle								1 X Yas 2 □ No
	vith the Mar or 28a-f s be noutled	Maryland Montg	omery	Gai	thersburg 101. Zip Code			log. Citizan of Wh	nat Country?
	with with Dig	419 Russell Ave	enue #212			20877		United	
21215-0020	filed within 72 hours efter death with the Maryland Hygiena. ther than "natural", or items 23a or 23-4 show out, the Medical Exercises trust to incuffed a Completed by Funeral Director	11. Marital Status  1 Nevar Marriad 2 Mar  3 Widowed 4 Divorced	12. Was Decedar Armed Forcas 1 ☐ Yas 2 Ž If Yas Giva	s? No	13. Was Decedant of If Yas, specify Cul		pecify Yas or No- o Rican, etc.)	14. Rece- Black, Specify:	- Amaricen Indian, White, etc. White
0-0	2 hox	15. Decedar	nt's Education	16a	Decedent's Usual Occu	pation	deina	16b. Kind of Busi	inass/Industry
218	led within 72 hor lygiena. The the netural th, the Medical	(Specify only highs Elemantary/Secondary (0-12)	ast grada completed) Collega (1-4o	or 5+)	(Giva kind of work done lifa. DO NOT usa ratin			United S	
	other than vent, if Mygiena.	12		Pe	rsonnel Sup	-		Post Off	
Maryland	ges 1 and 2 should be filed within 72 hr to I Health and Mentel hygiena. If item 27 is marked other than "nature or other treumatic event, the Medical Completed	17. Fathar's Neme (First, Middla,	Robert	Grago			na <i>(First, Middl</i> e, eta Taylo		
3	2 should be and Mentei is marked o eumatic eve								7: 0:41
Ma	12 sh h and h is rr reum	19e, informant's Name/Ralations			. Melling Address (Stree				
	1 end 1 Health em 27 i	John H. Nolan/	Husband	20b. Place 0	19 Russell  * Disposition (Nama of		Data		ity or Town, State
Baltimore,	P. P	1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S		te cameta	ry, cramatory or other pl ery Crematorio	um, Inc.	Mar. 31, 2000	Bethesda	, Maryland
Balt	permit. Departulmports eny inju	21. Signature of Funaral Sarvice	Licensee	M01126	Rockville	Inc., 3	00 West	Montgome	Funeral Home/ ry Avenue,
		23a, Part 1, Enter the disease of	complications that caus		Rockville	. Marylan	d 20850-	2805	Approximate
	Physician	23a. Part 1. Eritur The riseasus shock, or heart feilure. Un	conty one causa on aach	line.					Interval Between Onset and Death
	/Medical	Immediate Cause (Finel	as	perio	touch			,	3 weeks
	Examiner	disaasa or condition rasulting in daath)		Due to (or as a	consequence th:	note	core.	a	a wege
	je je		ELD	place	eder.	moto	lite		
	ificete be asscuted g physician end as the buriel-transit	Sequantially list conditions,	(	Due to (or as a	consequence of:		1		
0,	ian el	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants	<b>)</b> .				1		
68760,	ficete be physicie is the bu	that initiated avants rasulting in death) Last	G	Due to (or as a	consequence of):				
	500		L .						
Box	The law requires that the death cent sate has been signed by the ettending page 2 should be deteched for use Completed by Physician/M								
o.	the check	Part II. Other significant conditi	ons contributing to death	but not rasulting i	n tha undariying causa g	givan in Part I	23b. Dld t		ributa to the cause of death?
0	ed by the deteched	Pulmone	uf felice	sec	Pulm	mary	101	res 2 No	3 Probably 4 Unknown
Records,	signed to be de	(	10			acht	24a. Was	an autopsy	24b. Wara autopsy findings
Ö	been si should leted	atriol	elevill	alem	Voca	land	perfor	med?	evailable prior to completion of ceuse of death?
Re	has ge 2 in mpl	1.1	1		11 for	rolyses	·	· 011	
	certificata rector, pag	25. Wes case referred to medica	mara	4m	Angenu	affects	ecc 101		1 Yas 2 No
Vital		exeminar?	Hospital:	atiant 2 ER/O	utpatient 3 DOA	Other	ath <i>(Check only o</i> Home 5 ☐ Rasid		(Spacify)
of		27. Manney of Death	28a. Data of In (Month, E			ury at lork?		now injury occurre	
O	ding F th. After funer	1 Neturel 5 Pandi 2 Accident invest	ing (Month, Ligation	Day Yaar)		Yes 2 No			
Division	Attending or deeth.  octor: After by the fune iffication	3 Sulcide 6 Could	not be 28a. Place of I	Injury - At homa, to	arm, straet, fectory, office	е	281. Location (S	Street and Number	r or Rurel Routa Number,
D	tal or Attending Pris effor deeth. In Director: After ted in by the funers Certification:	4 Homicida	building,	etc. (Specify)			City or Tow	m, Stata)	
	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: Attenth complately filled in by the funeral Medical Certification:		ng Physician: To the basis i Examiner: On the basis and menner	of axamination ar					
	ithin ithin on the comple	29b. Signeture end titla of certific		oratou.	29c. Lice	nse number		29d. Data signed	(Month, Day, Year)
	_	1101	4.12	/	. ()	6111.	_	mare	72 2000
	10	30. Neme and address of person	who completed asset	death (Ham 22-1	(Type Brint)	04115		· wich	-2/12000
		H. Robert Birs				vd. Beth	esda. Ma	rvland 2	0817-1664
	State	31. Data filed (Month, Day, Year	) 32. <b>Pe</b> gis	strer's Signature	1.11	4	-Dudy Ha	- , - unu 2	551, 1004
	Registrar	MAR 31		evas /	9. sport	2			9



#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dey Month Lester L. Olinger Ja March 25, 2000 12:23 pm 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Yeer | If Under 24 Hrs. Months Deys Hours Min. 8. Data of Birth (Month, Day, Year) Dec 2, 1935 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foraign Country) Months 1X M 2□F 64 Yrs. 220-32-6322 DC Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 508 Fleetwood Street 20910 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Merital Status Bleck, White, etc. 1 Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17 Father's Nema (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada E. Combs Lester L. Olinger, Sr. 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Ellen Longsworth / Sister 670 Greenbridge Road, Brookeville, MD 20833 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition Deta 20c. Location - City or Town, State 1 XBuriel 2 Cremetion 3 Removel from Stete 3/29/00 Rockville, MD 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park \_22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel Vascular disease 104 car. disease or condition rasulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initiated evants resulting in daath) Last Due to (or es a consequance of): Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Renal 24b. Wara eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after Hygiene. ther than "natural", or ite

permit. Pages 1 and 2 should be filled will Department of Health and Mertel Hygiens Important: If Nem 27 is marked other that any injury or other traumatic event.

altimore, Maryland 21215-0020

Box 68760,

Records, P.O.

Division of Vital

Director

Funeral

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Completed

Be

Examiner Physician/Medical à Completed Be Certification: To

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera After

1 ☐ Yes 2 ☐ No

25. Wes case raterred to medical axeminer? 26. Placa of Daeth (Check only ona) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yes 2D No 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 DeNatural 1 ∏Yas 2 ∏No 2 Accidant 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 4 ☐ Homicida

29a. Certifier (Check only one)

🔀 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred et tha time, data end place, and due to the cause(s) end menner stated.

29b. Signeture end title of commission

29c. License number D35103 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

6240 Montrose Rd Rockville mo Vaccare 334 Stephen 31. Date filed (Month, Dey, Year)

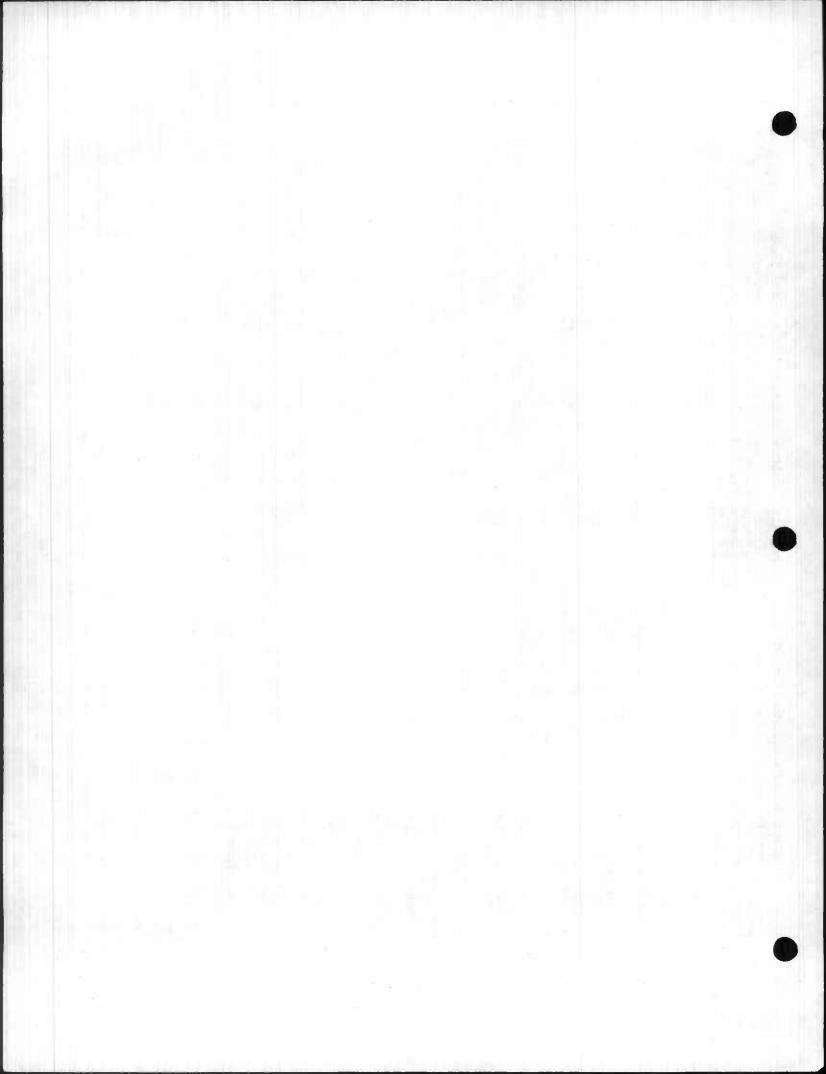
State Registrar

10

Medical

32. Registrer's Signature MAR 27

MO



State of Maryland / Department of Health and Mental Hygiene

			State of Ma	a ylarıcı /	Certificat			z mornar riy	Reg. No.	00	11804
Physicia	1. Decedent's Name (I	First, Middle, Last,	DATA	K !	Rache	4		2. Dete of De Month March	25, 2000	Year	3. Tima of Death 8:26 AM
/Medica Examine	de Feelite Nome ///	nt institution, give	street and number		1010-0		b. City, Town,	or Location of Deal			0.20 AM
Funeral Director	SHADY GI 5. Social Security Num 333-22-483	ber 6. Se		HOSPI (In yrs. last b			ROCKV If Under 24 H Hours M	ITLLE  Irs. 8. Date of Bi (Month, Di May 15	rth	TGOME 9. Birthpla Countr III	ERY ace (State or Foreign y) inois
9	Usual Residence of De	ocedent Ob. County		10c. City. Toy	wn or Location					100	d. Inside City Limits
Maryt Hed at		Montgome	ry		ntgomery	Vil	lage				1 ☐ Yes 2 No
with the Marylan a or 28s-f show Lbs notified at	Maryland 10e. Street and Number 9841 Sailf		ace	10-17	10f. Zip		0886		10g. Citizen of V		
-0020 hours after death with furer; or fleme 23a of al Examinar must b	11. Marital Stetus 1 Nevar Married 3 🖾 Widowed 4	2 Married	12. Was Decedent E Armed Forces? 1  Yas 2 N If Yes, Give Yeer or Dates:		13. Was Decell Yes, spe	dent of H cify Cubs	ispanic Origin? In, Mexicen, Pu	(Specify Yes or No erto Rican, etc.)		e - America ck, White, et	n tndien, lc.
Maryland 21215-0020 at 2 should be flied within 72 hours at the and Mental bygone. The marked other than "natural", or traumetto event, the Medical Exert	(Specify Elementary/Seconds	Decedent's Edu only highest grade ary (0-12)	cation e completed) College (1-4or 5		a. Decedent's Usua (Give kind of wo life. DO NOT u	rk done o se retired	ation during most of v f)	working	16b. Kind of B		istry
d 2 Hygie dhart		st, Middle, Last)			Secreta	ary	18. Mother's N	lame (First, Middle	Law F		
rian Mental Med ov	Davis S. S						Claud	ine Chat	ten		
Mary d 2 sho th and h 7 is me treume	19a. Informent's Name							Rural Route Numb			
Hasth Hasth Her tr	Jeffrey Le		7 50n		of Disposition (Ner		Place,	Frederic	20c. Location		
Baltimore, semil. Pages 1 ar Department of Hear Important: If Hear Into Hear		cremation 3 R	emoval from State	cemete	omery Cre	other pled		March 27,	Bethesd		
Ball permit permit import eny in	21. Signature of Funer	al Service Licens	//	0672	Rockvi Rockvi	11e,	ss of Facility R Inc. Maryla	obert A. 300 West nd 2085(	Pumphre Montgom 0-2805	y Fune ery Av	eral Home/ venue,
	23a. Part1. Enter the a	disease, or compli bilure. List only or	cations thet ceused ne cause on each tin	the death. Do							Approximata Interval Between
Physician / /Medical Examiner	tmmediate Cause (Fin disease or condition resulting In death)	al	Breast		consequence of):						Onset and Death
D #	a constant			D00 (0 (0) 83 8	consequence or,					1	
68760, ficate be executed physician and is the bunal-transit	Sequentiatly tist condition if any, leading to imme ceuse. Enter Underly! Cause (Disease or inju	dions, ediate ng		Due to (or es a	consequence of):						
W = 0 = .	resulting in death) Las		1	Due to (or as a	consequence of):						
death cert death cert e attending	Part tt. Other significa	nt conditions cor	tributing to death bu	t not resulting	in the underlying of	cause giv	en in Part I.	23b. Dlo	I tobacco uae co	entribute to	the cause of death?
by the								1	Yes 2 No	3 Probe	ably 4 Unknown
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The lay ate has page 2	5							10	Yes 210 No	10	Yes 2□ No
Of Vital Physician: The this certificate ral director, page	25. Wes case refarred examiner?		lospital: , xx			Oth	or.	Death (Check only			
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Division  Nospital or Attending 24 hours after death. Funeral Director: After		Could not be determined	28e. Plece of Injubuitding, etc	ry - At home, i . (Specify)	arm, street, factor	y, office		28f. Location City or To	(Street end Num. own, Stete)	ber or Rural	Route Number,
Hospi 24 hou Funer stely fill	29a. Certifier 12	Certifying Phys Medical Examin	sician: To the best of ner: On the basis of and manner sta	examination e	e, death occurred nd/or investigation	at the tir , in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time	cause(s) and m , date and place,	anner as sta and due to	ited. the cause(s)
To the within To the comple	29b. Signature and title	of certifier	11/	11	29	c. Licens	e number		29d. Date signe	ed (Month, D	Pay, Year)
25	1 -	N	/ M	M	MA	D.	33686		March 2	5, 200	0
	30. Nema and address Kenneth D.					Lip I	Orive,	#327, 01r	ney, Mar	yland	20832
State Registra	1886	2 7 200	_	r's Signeture	b. Soo	als	/				

DHMH 16 Rev 6/95

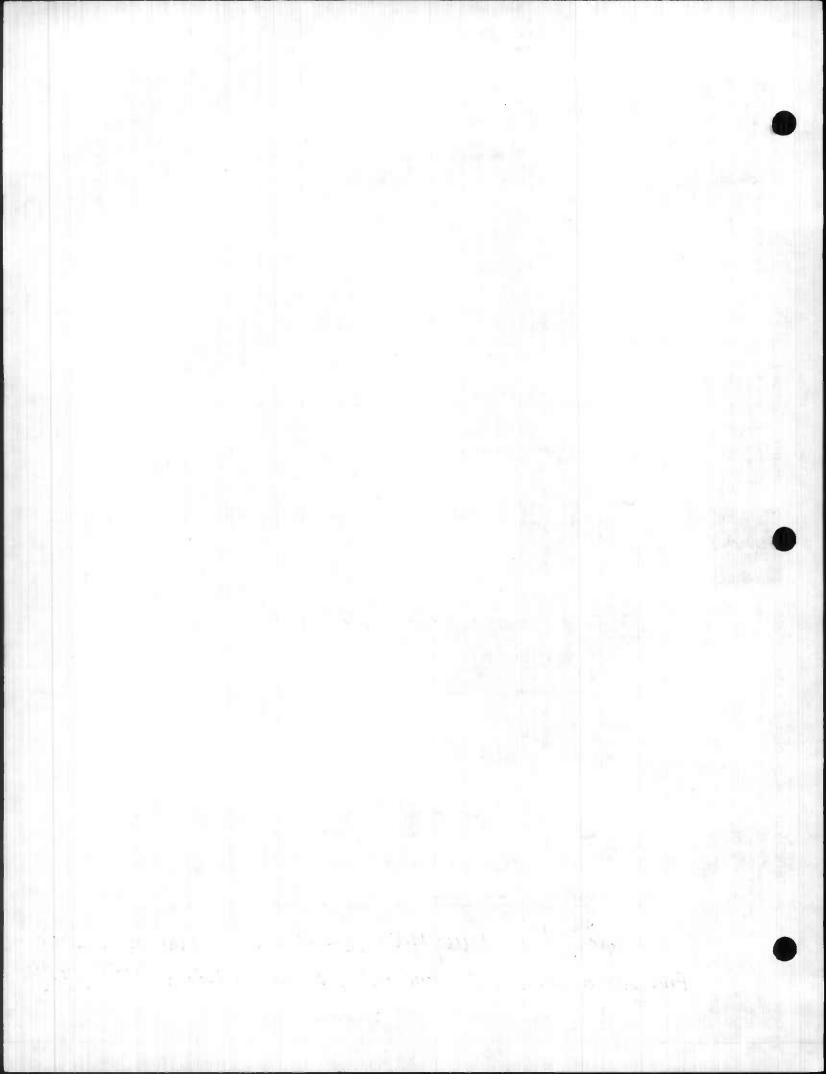
amend item 23a,27 per me G782 4/12/00 yg 00-1715-031 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene ROBERT MICHAEL 805 Certificate of Death PETERS 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month **Physician** 26, ROBERT PETERS M. MARCH 2000 09:51 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner 796 QUINCE ORCHARD BOULEVARD #201 GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey. Birthplace (State or Foreign Country)
 CALIFORNIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2□ F Yrs. 554-62-7648 MARCH 22,1945 **Director** Usual Residence of Decedent 10a. Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Manylen Lil hygiene other than "natural", or flams 23a or 28a-f show vent, the teroites Examine manthe noutried as 1 No Yes 2 No Director MD. MONTGOMERY GATTHERSBURG 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 20878 796 QUINCE ORCHARD BLVD.#201 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: py Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) DESIGNER SELF EMPLOYED permit. Peges 1 end 2 should be filled w
Department of Health and Mental Hygier
Important: If them 27 te marked other th
any injury or gither traumatic event, in-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be CHARLES GERALDINE SIMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Numbar, City or Town, Stete, Zip Code) DEBORAH JEAN PETERS/WIFE SAME AS ITEM 20a. Mathod of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/28/00 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 20906 rome MOOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximete Intarvat Batwaan Onset and Death **Physician** /Medical Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequance of): Box 68760. edical the Due to (or es a consequence of) Physician/M 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown Records. þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 Xes 2 No of Vital 25. Was case referred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home > Residence 6 ☐ Other (Specify) P X□ Yes 2□ No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28d. Dascribe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Certification: Division or Attending 5 Pending 1 K Natural 1 ☐ Yes 2 ☐ No after death. investigation Director: A 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital o within 24 hours af To the Funeral D' completely filled i Medical 1 Certifying Physician: To the best of my knowledga, daafh occurred at the tima, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier OCME MARCH 27, 2000 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) HERDORE 1 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura 2000 MAR 28 Registrar

100 3/ 2 = = = 1,71. 

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death		Reg. No.	U	11806		
	1. Decedent's Nema (First, Middla, Le	st)				2. Dete of De	eth	Vaar	3. Time of Death		
Physician /Medical	FATEMEH E.	PISHEH-MIR	VAHABI			MARCH	21, 200	O Year	10:48 AM		
Examiner	4a Facility Name (If not Institution, git	re street and number)			4b. City, Town, or	Location of Deal	h 4c. County	of Deeth			
	7904 OTTER COVE	COURT			GAITHER!	BURG	MON	TGOME	ERY		
Funeral Director	213-13-9701	DM ODE	70 Yrs. last birthda	Montha Deys		(Month. De	th ey, Year) 0, 1930	9. Birthp Cour Ira	elece (Stete or Foreign etry) LD		
Pu a	Usuel Residence of Decedent  10a. Stete 10b. County		Od. Inside City Limits								
position of a should be filed within 72 hours after death with the Meryland Depertment of Heath and Mental Hygiene.  Depertment of Heath and Mental Hygiene.  Primodrant: If them 27 is marked other than "natural", or terms 23e or 28e-1 show eny injury or other traumatic event, the Medical Evantian must be notified and injury.  To Be Completed by Funeral Director	Maryland Montgon		c. City, Town or Gait	hersburg			1 D				
th with the 23s or 2 sector 23	10e. Street and Number 7904 Otter Cove (	Court		10f. Zip Code 20886			10g. Citizen of V	What Cour	ntry?		
r tems 23s	11. Maritel Status	12. Was Decedent Eva Armed Forces?	r in U,S. 1	3. Wea Decedent of If Yas, specify Cub	Hispanic Origin? (S	pecify Yes or No	o- 14. Rac	e - Amaric	an Indian,		
al', or h	1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		1□ Yes 2X No			Specify	y:	ite		
n 72 hours "natural", udelled by	15. Decedent's E			cedent'a Usual Occu va kind of work done		tina	16b. Kind of B	usiness/In	dustry		
be filed within 72 hours of tall Hygiener 19 october than "natural", or event, tre Mindrell Erang.	(Specify only highest grant (S	College (1-4or 5+)	life	DO NOT use retire	ed)	King	Own 1	Home			
The state of	17. Father's Neme (First, Middle, Last	)			18. Mother's Ner	ne (First, Middle	, Maiden Sumen				
should be and Mental oursetic even	Abdollah Eda	lat Pisheh			Talat		Hashami				
nod &	19a. Informant's Neme/Reletionship		19b. Me	eiling Address (Stree		ral Route Numb		Stete, Zip	Code)		
and 2 should be file and 2 should be file as the marked other for traumatic event	Farin Mirvahabi,	Daughter		Rose Lan			, Virgi		22042		
Health Health Hem 27	20e. Method of Disposition		20b. Plece of Dis	position (Neme of		Dete	20c. Location -				
Dearli. Pages 1 ar Depertment of Hea My injury or other MGE.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donalion 5 ☐ Other (Special	50	Marylan	d National	l Cemeter	3/23 y 2000	Laurel	, Ma	ryland		
pemit. Pag Depertment Important: i eny injury o	21. Signature of Funeral Service Los	4		22. Neme and Addr			ol Funer				
<b>D</b>	23a. Part1 Enter the chase, or conshock, or heer training. List only	plications that caused the one cause on each line.							Approximete Interval Between Onset and Death		
Physician /Medical	Immediete Cause (Finel disease or condition	DIABETES	MELLITU	JS					5 YEARS		
Examiner	resulting in deeth)	8.	to (or as a cons					JILAKS			
Jer de		HYPERLIP	IDEMIA						5 YEARS		
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certifica nding ph use as ti	resulting in death) Last	d. END STAGE	E CARDIO	МУОРАТНУ				1	2 YEARS		
et the death certing d by the attending etached for use a Physician/M	Pert II. Other significant conditions of	contributing to death but no	ot resulting in the	underlying ceuse gi	iven in Part I.	23b. Did	tobecco use co	ntribute to	o the cause of death		
ires that the death certises that the death certised by the attendir d be detached for use by Physiclan/A						10	Yes 2 No	3□ Pro	bebly 4 ☐ Unknow		
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ysicien: The is secriticate he director, page	25. Wes case referred to medical				26. Place of Dec						
Physicien: this certific val director,	examiner?	Hospitel: 1 ☐ Inpatient	2 ER/Outpat	ient 3 DOA Ot	4		idence 6 DOth	nr /Canai	6.1		
ng Ph her th neral	27. Manner of Death 1 X Netural 5 ☐ Pending	28a. Date of Injury (Month, Dey Ye	28b. Time	of 28c. Inju	ork?	1	how injury occur		y)		
To the Hospital or Attending Physicien: To the Hospital or Attending Physicien: To the Funeral Director: After this certifical completely filled in by the funeral director, p. Medical Certification: To Be C.	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injury	M 1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number City or Town, State)			
Hospita     24 hours     Funeral letely fille  dical C	29a. Certifier TE Contyning P	niner: On the best of m	aminetion and/or	eth occurred at the trinvestigetion, in my	ime, date end place opinion, deeth occu	, and due to the	cause(s) end mo	enner es s and due te	tated. the cause(s)		
To the within To the comp	29b. Signature and title of duringer	Lunger	W/M.	1). 1	se number 4020		29d. Date signe MARC	H 2	12000		
(2)	30. Neme and address of person who FAR ZAD ASSA	completed ceuse of death	(Item 23a) (Typ	Print)	VILLAGI	E AVE.	F-24 C	MAITH	1 ERSBUR() 20886		
State Registrar	31. Data filed (Month, Day, Year) MAR 2 8 2	32. Registrer's	Signature	Look	2	-			7.7.4		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene \( \int \) Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Year March 29, 2000 3:37AM Poppa 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery ff Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1 M 2 F Months Yrs. 91 March 10,1909 Albania 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland | Montgomery Bethesda 10f. Zlp Coda 10g, Citizan of What Country? 5405 Beech Avenue 20814 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, 12. Was Decedant Evar in U,S. Black, Whita, atc. Armed Forces?
1 ☐ Yas 2X No 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced Yaar or Datas: White Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Proprietor Luncheonette 18. Mother's Nama (First, Middla, Meidan Surneme) 17. Fether's Neme (First, Middle, Last) Vaslia 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) Geraldine Schechter/Daughter 5405 Beech Avenue, Bethesda, Maryland 20814 20b. Place of Disposition (Nama of cemetery, crematory or other place) Deta 20c. Location - City or Town, Stete 1 Buriai 2 □ Cramation 3 □ Removel from Stata Apr. 1 4 ☐ Donation 5 ☐ Other (Specify) Cypress Hills 2000 Brooklyn, New York 22. Neme and Addrass of Facility Robert A. Pumphrey Funeral Home Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin 21. Signature of Furneral Sarvice License M00803 Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer feilure. List only one cause on adch line. Approximata Interval Between Onsat and Daeth

**Physician** /Medical Examiner

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attending physician e for use es the buriel-

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Physician/Medical

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Certification:

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

the Marylend r 28a-f ahow

he filed within 72 hours efter death with all Hygiene.
I other than "natural", or frame 23a or yeart, the Medical Examines must be a yeart, the Medical Examines must be a

27 la marked other traumatic evant,

permit. Pages 1 end 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked other any Injury or other traumatic event, pages.

Baltimore, Maryland 21215-0020

Victoria

5. Sociel Sacurity Number

053-30-8723 Usual Rasidance of Dacadan

10e. Street and Number

8

Venemin Nosi

20a. Method of Disposition

will

11. Marital Status

10a, Stata

Directo

Funeral

by

Completed

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Sequantially list conditions, if any, laeding to immediata causa. Entar Undarlying Causa (Diseasa or injury that initiated avants resulting in death) Last

Immediata Ceuse (Final disaasa or condition rasulting in death)

Heart Failure

Dua to (or as a consequence of):

Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of):

Cerebrovascular Accidents

Dua to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Wera autopsy findings available prior to completion of cause of death?

1 Week

Years

Years

1 ☐ Yas 2 💢 No

1 ☐ Yas 2 No

25. Was cesa rafarrad to medicel axaminar? 1 Yas 2 No 27. Mennar of Death 1 Natural

5 Panding investigation

6 ☐ Could not be

Hospital:

28a. Date of Injury (Month, Dey Year)

1 Inpatiant 2 ER/Outpatient 3 DOA 28h. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4X Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

28. Place of Death (Check only one)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

2 ☐ Accident

3 ☐ Suicida

4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred et tha time, deta and plece, and dua to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. Licansa number

29d, Data signed (Month, Day, Year)

D0019785

March 29, 2000

30. Name and addrass of person who completed causa of death (Itan 23a) (Type, Print)

2000

809 Veirs Mill Road, Rockville, Maryland 20851 Frauke Westphal, M.D. Dey, Year)

State Registrar

32. Registrar's Signatura

souks

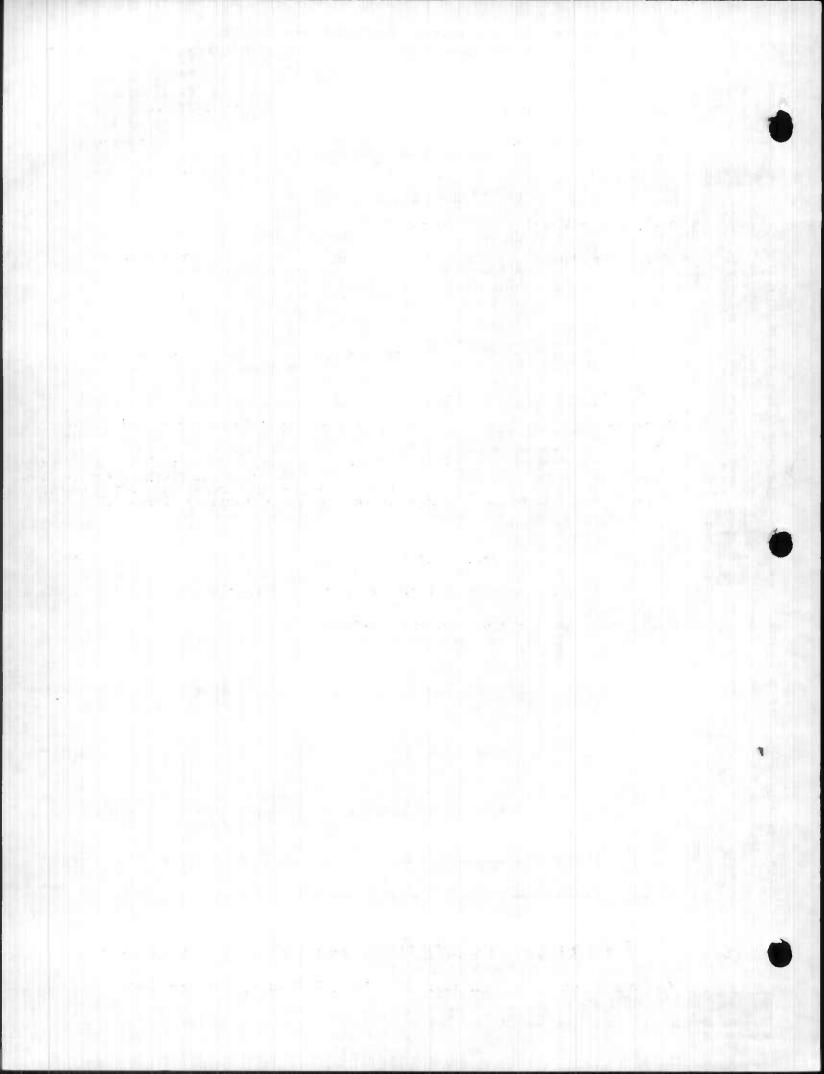
**DHMH 16 Rev 6/95** 

Box 68760. o Records,

The law requires that the death certificate be executed

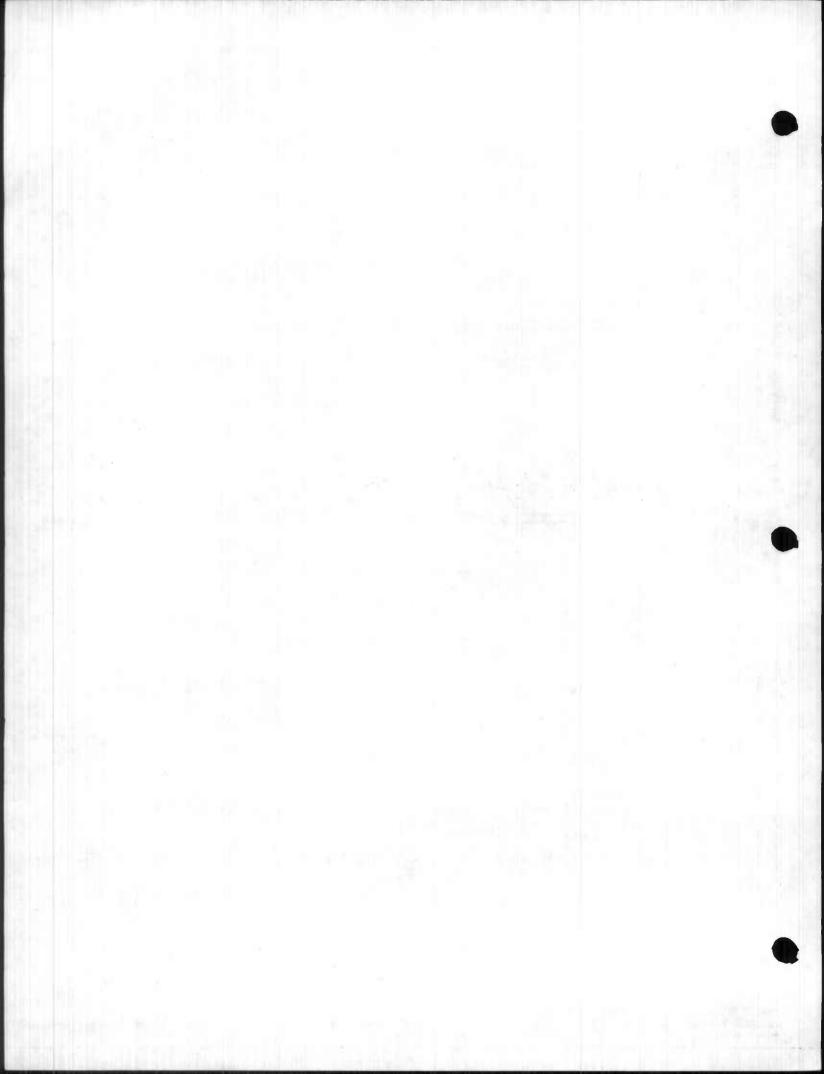
Division of Vital Physician: or Attending Hospital

within 24 hours eff To the Funeral DI completely filled in 12



State of Maryland / Department of Health and Mental Hygiene 00 11808

				Ce	rtificat	e of	Death			Reg. No.		11000	
	1. Decedent's Nama (First, Middle, L.	est)							2. Data of Dec	ath	V	3. Tima of Death	
cian lical	LOUISE SMITH PE	ETTUS							Month MARCH	29,	2000	13:40 PM	
iner	4a Facility Nama (If not institution, gi	ve street and number	)				4b. City, To	wn, or Lo	cation of Death		nty of Death		
	DOCTORS HOSPITA	AL.					LANH	AM		PRIN	CE GEO	RGES	
1	579-40-7512	Sax 1□M 2ŽF	ga (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Data of Birt (Month, Day AUGUST	19,19	9. Birthol Count 30 NEW	ace (State or Foreign Try) YORK	
	Usuai Rasidenca of Decedant  10a. Stata  10b. County		10c. City,								10	Od. Inside City Limits	
Director	MARYLAND PRINCE (	GEORGES	LAND	OVER	HILL								
	10e. Street and Number 3821 64TH AVENUE				10f. Zip		784			10g. Citizen o UNITED			
by Funeral	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces t  Yas 2 H f Yas, Giva Year or Datas:	?				Hispanic Ori an, Mexican Specify:		ocify Yes or No- Rican, etc.)	Spec	lace - America lack, White, e	olc.	
pot	15. Decedent's E			16a. Dece	dent's Usua	al Occup	pation during most	d od wordsi		16b. Kind of	Business/Ind	ustry	
Completed	(Specify only highest gr Elementery/Secondary (0-12) 11TH GRADE	College (1-4or	5+)	life.	JNDRES	se retire	during mosi od)	t or works		UNIFOR	M LINE	N SERVICE	
O	17. Fathar's Nama (First, Middle, Las	1)					18. Mothe	or's Name	(First, Middle,	Maiden Sum	ame)		
To Be	TYLER SMITH						EARL	ENE (	DAKS SM	ITH			
-	19a. Informant's Name/Reletionship	(Type, Print)		19b. Mailie	ng Addrass	(Street	and Numbe	er or Pure	I Route Numbe	er. City or Tow	m. State 7in	Code)	
	WILLETTE ABBEY /	DAUGHTER							OVER HI				
	20a. Mathod of Disposition	DUOGIITEK	20b. Plac	of Dispo	sition (Nar	ne of		7.47	Data		n - City or Tox		
	1X Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special Superior of Funeral Foreign Loss)	ify)			MEMOR:			4,	/1/00			MARYLAND	
Physician/Medical Examiner	Immediate Cause (Final diseasa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	c	Dua to (or a	s a consec	quence of):							years years.	
hysic	Part II. Other significant conditions	contributing to death t	out not rasultin	ng in tha u	nderlying o	ausa gi	ven in Part I		1000	lobecco use (		the cause of death?	
Completed by P									24a. Was	an autopsy med?	24b. We	ore autopsy tindings sitable prior to inplation of cause leath?	
E									101	(es 2 No		Yes 2 No	
	25. Was casa rafarred to medical						20 01-	of Descri		/	1	J 169 Z L 190	
Certification: To Be	axaminer? 1		Jry 28	VOutpatier Bb. Time of Injury		Bc. tnju Wo	her: 4 Nu	rsing Hor	n <i>(Check only o</i> ma 5 ☐ Resid 28d. Describe h	dence 6 🗆 C		')	
E	3 Suicide 6 Could not be datermined	28a. Placa of in	c. (Specify)						City or Tow	vn, State)		Route Number,	
Certi			-A 1 - 1	doe deati	n accourand	at the ti	ma, data an	d place, a	and due to the	cause(s) and	menner as st	ated.	
edical Certi	29a. Certifiar Certifying Pl	hyatclan: To the best miner: On the besis o and mannar st	f axeminetion	end/or in	vastigation	, in my o	opinion, dea	th occurre	ed at tha time,	data and plac	e, and due to	the cause(s)	
ledical	(Check only 2 Medical Exam	miner: On the besis of	f axeminetion	end/or in	vastigation	, in my o	opinion, dea se number	th occurre		data and place 29d. Date sign		the cause(s)	
Medical	(Check only 2 Medical Example one)  29b. Signatura and title of certifiar  Aurum	miner: On the besis of and mannar st	f axeminetion ated.	end/or in	vastigation 290	, in my o	se number			29d. Date sig	ned (Month, I	the cause(s) Day, Year)	
Medical	(Check only 2 Medical Example)  29b. Signatura and title of certifiar	miner: On the besis of and mannar st	f axeminetion ated.  Multiple	end/or in	vastigation 290	, in my o	se number			29d. Date sig	ned (Month, I	the cause(s) Day, Year)	



ALBERT N. PROCTOR

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

State of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27 PER MEO G7Z8 Certificate of Death

Reg. No.

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00		-	O	U	

7 1 1
Physician /Medical
Examiner

Albert N. Proctor 4a Facility Name (If not institution, give street and number)

6 Sex

1 1 M 2 □ F

MARCH 4b. City, Town, or Location of Death

Min.

2. Date of Deeth

3. Time of Death 2000 Par 1940

5. Sociel Security Number 212-92-3627

FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) Days Hours

PRINCE GEORGES

**Funeral** Director

28a-f show

'natural', or thems 23a or

hours after

Hygiene

should be and Mental th and Mental 7 is marked of traumatic eve

permit. Pages 1 and 2 sh. Department of Health and important: If them 27 is mer

Baltimore, Maryland 21215-0020

must be

Directo

Funeral

à

Completed

96

2

Usual Residence of Decedent 10s State 10h Counh Maryland Charles 10e. Street and Number

1. Decedent's Name (First, Middle, Last)

FORT WASHINGTON

10c City Town or Location

35

8. Date of Birth (Month, Dey, Year) May 22,64

28ay

 Birthplace (State or Foreign Country) Washington D.O

10d. Inside City Limits

Waldorf 10f. Zip Code

Yrs.

1 Yes 2 No 10g, Citizen of What Country?

4c. County of Death

9711 Hoppy Place 11 Marital Status 1 ☐ Never Merried 2 ☐ Merried

12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:

20603 Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 3€ No Specify:

U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

HOSPITAL

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Self- Employed

16b. Kind of Business/Industry

12 17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

Mechanic

18. Mother's Name (First, Middle, Maiden Surneme)

John W. Proctor 19a. Informant's Name/Relationship (Type, Print)

Mary Proctor 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

Mary Proctor/ Mother

9711 Hoppy Place Waldorf Maryland 20603 20c. Location - City or Town, State

20e. Method of Disposition 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Smetery cremetory or other place)

April 5,2000 Pomfret MD

4 ☐ Donation 5 ☐ Other (Specify)

\$t.Josephs 22. Name and Address of Facility 11P100M

Adams Funeral Home P.A.Aquasco Maryland

20608

23a. Part. Enter the disease, or complications that assed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause of each line.

Approximate Interval Between Onset and Death

**Physician** /Medical

Immediate Cause (Final disease or condition resulting in death)

CARDIAC ARRHYTHMIA

Due to (or es a consequence of):
ABNORMALITY OF CORONARY ARTERY (TUNNEL) AND
FOCAL MILD FIBROSIS

Due to (or as a consequence of)

Due to (or as a consequence of):

Examiner Examiner

sician end burial-trans

attending physician for use es the buria

signed by the a

page 2 s

this funeral

ofter death.

Director: After

To the Hospital o within 24 hours of To the Funeral D completely filled i

Physician/Medical

by

Completed

Be

P

Certification:

Medical

Box 68760

Division of Vitai Records, P.O.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last

-				
art II.	Other significant conditions	contributing to death but not resulting	in the underlying cause	given in Part

23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

24e. Was an autopsy

24b. Were eutopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? XX Yes 2 No

27. Menner of Death 5 Pending investigetion

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

29a. Certifier

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and menner stated.

29b. Signal ure and title of cartifies Wire

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number O.C.M.E 29d. Date signed (Month, Dey, Year) MARCH 30, 2000

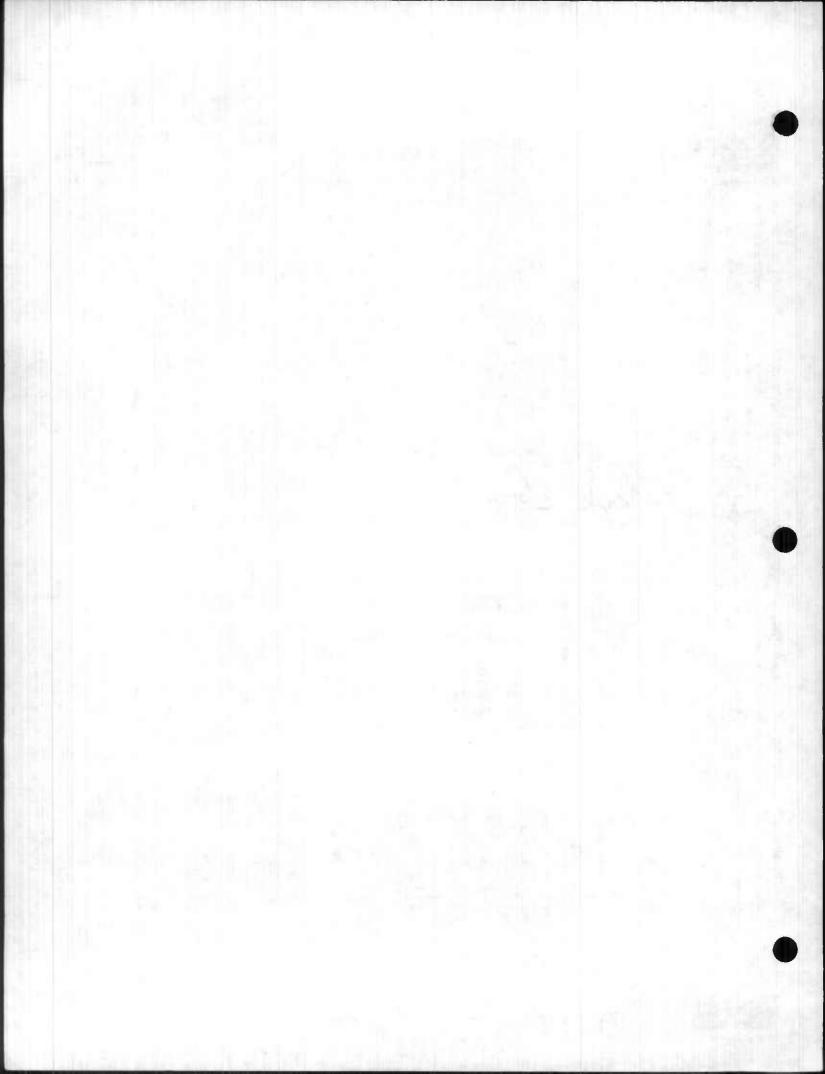
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 1 ARYARITA · KDRETU

Registra

31. Date filed (Month, Day, Year) MAR 3 1 2000 32. Registrar's Signature General

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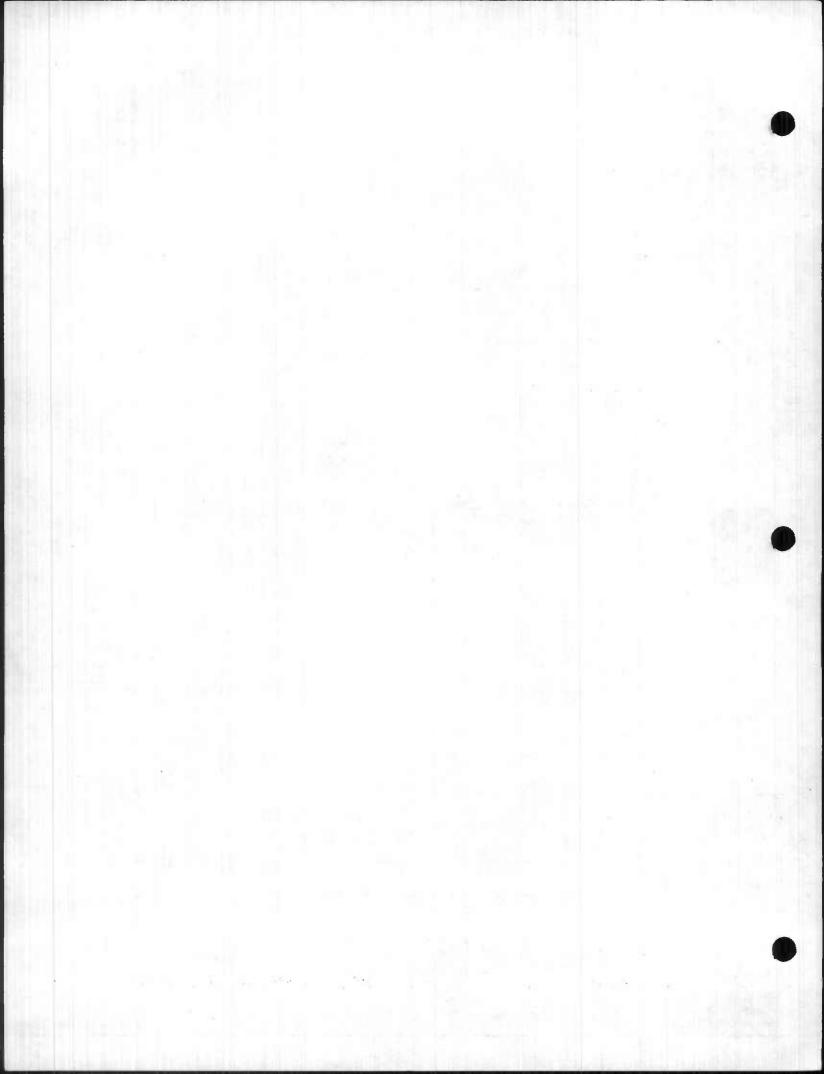


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death **Physician** 24, 2000 4c. County of Death Constance Ouallis March /Medical 11:35pm 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) Examiner 7 King's Wharf Place Waldorf Charles If Under 1 Year If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1□M 2CXF 66 Yrs. 214-47-1602 Director Feb. 07,1934 Guyana Usuel Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director St. Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 King's Wharf Place 20602 Funeral Guvana Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Evar in U,S. Armed Forcas? 11 Maritel Stetus filed within 72 hours after 1 Yas 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Black 1 Yas 2 No Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Department of Health end Mentel hygiene Important: If Item 27 Is marked other the eny injury or other treumatic event, that once the 12 Secretary Accounting 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Health end Mentel Wilfred T. Overton Rebecca Quallis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Abraham - Daughter 7 King's Wharf Place Waldorf, MD. 20602 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Guvana, South America 1 ₺ Buriel 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Lapentere Cemetery 4-01-00 Georgetown of Funerel Service Licenses 22. Name end Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediete Cause (Finel disaese or condition resulting in death) Examiner Examiner physician end the buriel-transit lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the ahould be deteched 1 Yee 2 No 3 Probably 4 Inknown Records, by 24b. Were autopsy findings eveilable prior to completion of causa of death? Completed 24a. Wes en autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 28. Place of Death (Check only one) Other: 4 Nursing Home .5 Tesidence 8 Other (Specify) Certification: To 1 Yas 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menper of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturat 5 Pending n 24 hours after deeth.

The Funeral Director: At plataly filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital edicai To the Hosp within 24 hor To the Funs complately fi (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier D28352 MARCH 26, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) POST OFFICE BOX 1703, LA PLATA, MARYLAND KRISHAN MATHUR, MD., 31. Date filed (Month, Dey, Year) 32. Ragistrar's Signeture State MAR 28 2000 Registrar

DHMH 16 Rev 6/95

CONSTANCE ETHELENE QUALLIS



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 2<sup>Day</sup>, **Physician** MARCH 2000 4:00 AM RHODES EDMONIA В. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner MONTGOMERY 12500 Kuhl Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 24, 1908 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 20 F 91 Yrs. 217-30-7032 Director Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits ¥ Yas 2 No Director Wheaton Montgomery MD 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20902 12500 Kuhl Road Name 23a U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after Hyglene. other than "natural", or he 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 Specify: Black 1 Yes 2€ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Home Domestic 3rd 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life. Department of Health, and Mantal Hy important: it lean 27 is marked other any Injury or other treatmetic event once. Be Clara Jackson Isaiah Brown 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 12500 Kuhl Road, Wheaton, MD 20902 Dorothy R. Carroll (Dau.) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Lincoln Park Cem. 3/28/00 Rockville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 20850 nousted ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Completed by Physician/Medical Examiner shysician and the burief-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Due to (or as a consequence of): 88 P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ardiomyopathy Records, The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? requiring pacemaker 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? 1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? \ffer 5 Pending investigation 1 Matural 1 Yes 2 No death. 2 Accident 24 hours after deal Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Yells)

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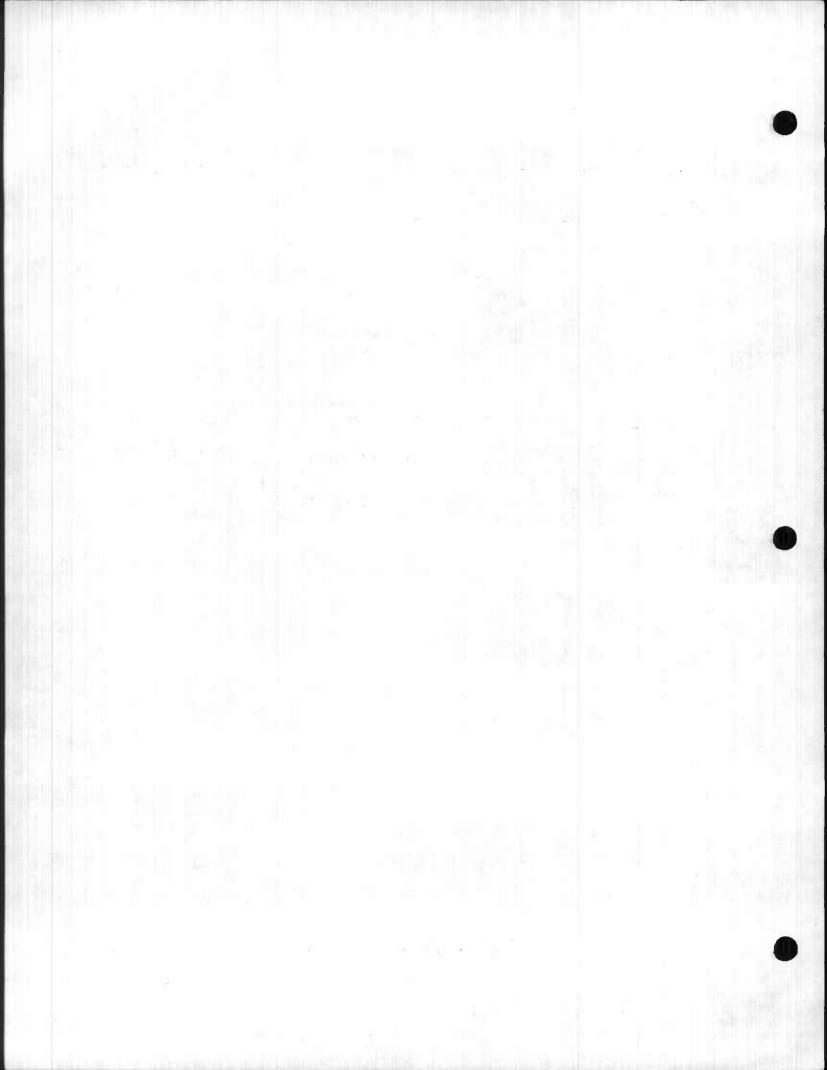
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32. Registrer's Signeture

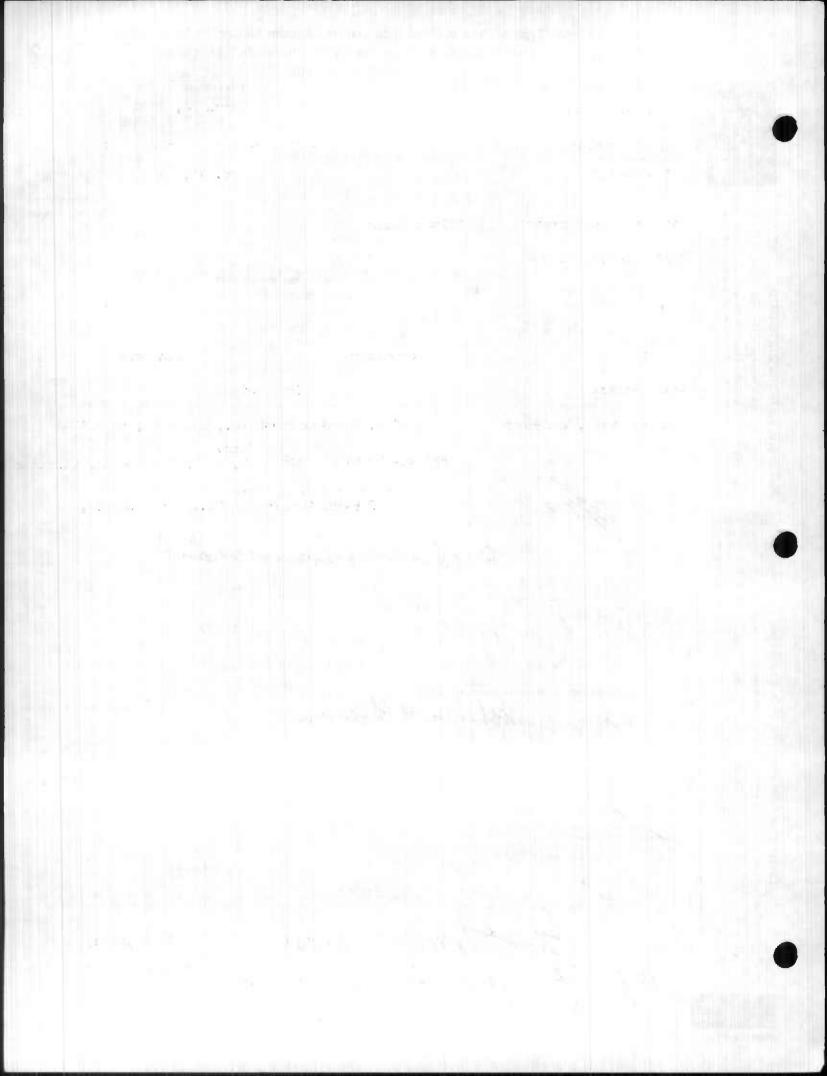
ve#400 Silver Spring MD 20910

Name and address of person who completed cause of deeth (Item 23a) (Type, Print)



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State of Maryland / Department of Health and Mental Hygiene

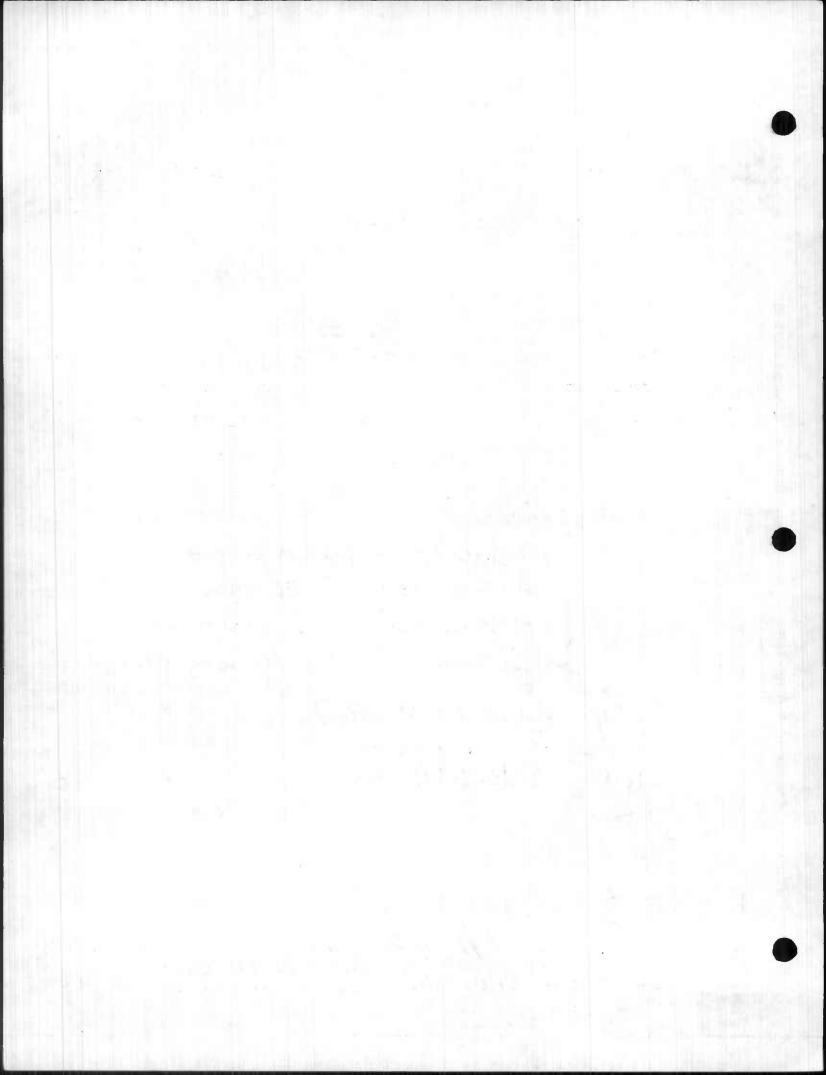
Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month **Physician** 28, FELIX C. MARCH 2000 7:25 AM /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5404 Odell Road Beltsville PRINCE GEORGES If Under 24 Hrs. Hours Min. If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 10 M 20 F Months 90 Yrs. Director 578-28-3652 Oct.31,1909 Maryland Usual Rasidence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits me 23a or 28a-f show 1 XYes 2 No Director Prince Georges Beltsville 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5404 Odell Road 20705 U.S.A. Funeral death Home 2 12. Wes Decedent Ever in U,S. Armed Forces?
1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: 44 — 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after d and of Habilith and Mental Hygiane.

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ury or other traumatic event, the Market Enamme. 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Black by 3 Widowed 4 Divorced 44-46 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 7th U.S. Government Meat Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Augustus Ross Gertrude Bruner 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Alice Ross (Wife) 5404 Odell Road, Beltsville, MD 20705 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete Important: If H any Injury or c 1X Burial 2 □ Cramation 3 □ Removel from Stete **Department** Nat'l Mem. Park 4 ☐ Donetlon 5 ☐ Other (Specify) 4/3/00 Laurel, MD 21. Signature of Funeral Service Milense 22. Neme end Address of Fecility SNOWDEN FUNERAL HOME P.A. 20850 ROCKVILLE, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart/failure. List only one ceuse on each line. Approximata Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disaasa or condition resulting in deeth) Examiner Due to (or as a consequence Medical Certification: To Be Completed by Physician/Medical Examiner The lew requires that the death cartificete be executed use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, evension Due to (or es a consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? cartificata hes 24 No 1 Yaa 25 No 1□ Yes Division of Vital To the Hospital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral di 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. fnjury at Work? Netural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date aigned (Month, Day, Year) 29b. Signeture and little of certifier 29c. License number M.D. 12 Sowie UREL cause of death (Item 23a) (Type, Print) 1 433 0 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State MAR 3 2000 0 Registrar



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			d/ Husba		1			d St., on				
	20a. Method of Dispo		Ramoval from St	-	emetery,	isposition (Na crematory or o	othar pia	M M	ar. 27	20c. Location -	- City or To	wn, State
) Š		Other (Specif		На	r Jel	huda Ce		ery	2000	Upper	Darb	y, PA
	21. Signature of Fund	eral Service Licer	nsee			22. Nama ar	nd Addra	ass of Facility Goldberg	Momoria	1 Chane	1e T	nc .
ă	1/	~	)				2	ille Pike				
	23a. Part 1. Enter the shock, or heart	disease, or com tailure. List only	plications that cer one ceuse on eac	used the dealt ch line.	n. Do not	enter the mod	de of dy	ing, such as cerdiac	or respiratory a	rest,	200	Approximate Interval Between Onset and Deeth
an cal ner	Immediate Ceuse (Fi disease or condition resulting in death)	inal	a. Mito	whe	Ba	an	6n	enhly	the	_		1 week

To the Hospital or Attending Physician: The lew requires that the death certificate be exected within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra Medical Certification: To Be Completed by Physician/Medical Exa

Division of Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Cenfre Dua to (1	TS.ch. or as a consequence of):	<b>~</b> Q		
Part It. Other algoriticant conditions co		sulting in the underlying o	cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death:
anting de	mu.		0	24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of ceuse of deeth?
				1□ Yes 2ŪNo	1 ☐ Yes 2 ☐ No
25. Was casa referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 No	Hospitel: 12 Inpatient 2	ER/Outpatient 3□ DO	OA Other: 4 Nursing	Home 5 Residence 6 □Ott	ner (Specity)
27. Menner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Dete of tnjury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	rred
3 Suicide 6 Could not be determined	28a. Place of Injury - At h building, etc. (Speci	nome, tarm, street, fector ify)	y, office	28f. Location (Street and Number City or Town, State)	ber or Rural Routa Number,
				ce, and due to the causa(s) and m curred at the time, date and place,	
29b. Signature and title of certifier	- /	29	c. License number	29d. Date signe	ed (Month, Day, Year)

State Registrar

30. Name and address of person who completed ceuse of death (Item 23a) (Type; Print)

7600 (Arrell Arrell
31. Date tiled (Month, Day, Year)

MAR 3 1 2000

32. Registrar's Signeture

33. Arrell
34. Arrell
35. Arrell
36. Arrell
36. Arrell
37. Arrell
38. Arrell
39. Arrell
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30. Arrell
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31. Date tiled (Month, Day, Year)

32. Registrar's Signeture

Waleed Kadro, MD

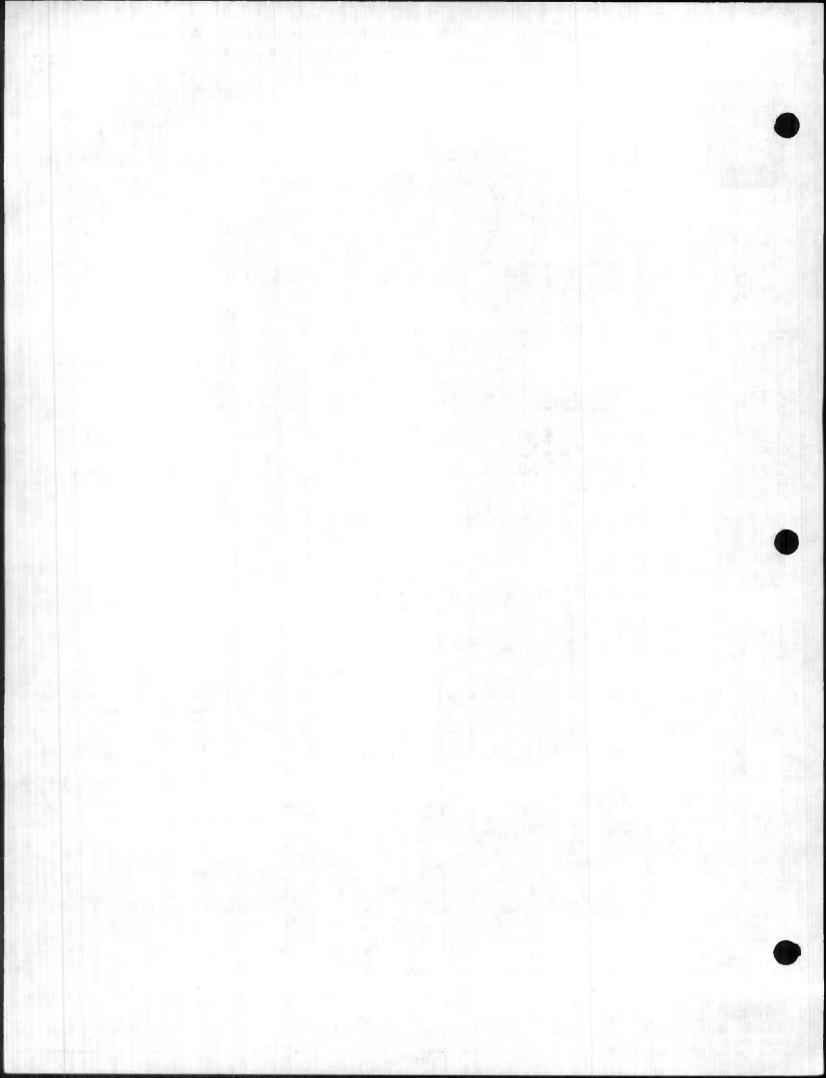


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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- 4	-			U

							UI Dealli		Reg. No.		
Physician /Medical	1. Decedent's N MIRIAM	ema (First, Middle, L	Last)		SACKS				of Deeth H 29, Day 20	000 Year	3. Time of Deeth 5:45 AM
Examiner	3310 NOT	e (It not institution of RTH LEISUR	E WORLD	BOULEV	ARD APT	r # 401	4b. City, Town SILVER	n, or Location of SPRING	Death 4c. C	ounty of Deett MONTGON	MERY
Funeral Director	5. Social Securit 035/22/2	y Number 6.	Sex 1 □ M 2 □ ¥F	7. Aga (In yrs.	lest birthday) Yrs.	If Under 1 \ Months D		Hrs. 8. Date Min. J M	of Birth th, Pay, Year 19	9. Birth	npleca (State or Foreign untry) RI
250	Usuel Residence										
be notified at Director	MD MD	10b. County MONTG	OMERY		ty, Town or Lo						10d. tnside City Limits 1 ☐ Yes 2X No
Street Street	10e. Street end	Number				10f. Zip Co	de		10g. Citize	n of Whet Co	intry?
				APT #		209	06				
Funeral	11. Meritel Statu	ORTH LEISU is arried 2 Married	12. Was Dec Armed F	edent Ever in U orces? 2 XNo	J,S. 13. V		of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes Puarto Rican, et	(c.)	ED STAT	, etc.
by		d 4 Divorced	If Yes, G Yaar or I	ve Datas:		LL TOS ZLZ	INO Specify:		5	pecify: Wit	HITE
Per		15. Decedent's	Educetion		16e. Deced	lent's Usual C	ccupation		16b. Kind	of Business/I	ndustry
Completed	Elementary/S	pecify only highest g econdery (0-12)	2 College (		HOME N		lone during most o etired)	f working	OW	N HOME	
o Be	17. Fether's Ner ABRAHAM	ne <i>(First, Middle, La</i> : BROUTH	st)			74	18. Mother's REGIN	Neme (First, A IA FELDE	Middle, Maiden Si CR	umeme)	
-	19e informent's	Neme/Relationship	(Type Print)		19h Mallin	n Address (S	treet and Number	or Rural Route i	Number City or	Town State 7	in Code)
											77
	ALAN SA	ACKS_(SON)		206	Diago of Dispo	sition /Name	EAF COURT	LAS VE		89134 Ition - City or	Town State
)	1 Buriel	2 Cremation 3 on 5 Other (Spec			cemerery, cren	netory or othe	GARDENS	3/30/		EY MD	OWII, SIGIO
Suc.	21. Signeture of	Funerel Service Lic	ensee		DAI	NZANKS	ddress of Facility I-GODLBEF  VILLE PI				
completed by Physician/Medical Examiner	Sequentially tist if any, leading to cause. Enter U Cause (Disease that initiated ever resulting in deat	conditions, o immediete inderlying or injury sorts	c	CO R	or as a consequence of	A RTS	ery dis	SE ASC			
SICI	Pert fl. Other sig	nificant conditions	contributing to	leath but not res	sulting in the u	nderlying caus	e given in Part I.	23t	Did tobacco u	se contribute	to the cause of death?
hy	11 4	ENTENSIC							1 Yes 2	No 3TOP	obably 4 Unknown
ed by		PERLIPIO						24a	. Wes en autops	1	Were eutopsy findings available prior to
omple		John Dem		Table 3					1 ☐ Yas 2 🗷		completion of causa of death?
Com		eferred to medical					ne Place	Dogth (Charle			
To Be	exeminer?		Hospital:		3 = 0 - 0		0.1	of Death (Check	/		4.4
tion:	1 Yas 2 27. Menner of D 1 Naturel 2 Acciden	eeth 5 Pending	28e. Date (Mor	-	28b. Time of Injury		Injury et Work? 1 Yes 2 No	28d. Des	Residence 6 scribe how injury		опу)
completely filled in by the funera  Medical Certification:	3 ☐ Suicide 4 ☐ Homicid	6 ☐ Could not	200. PIGG	e of Injury - At h ling, etc. (Speci	ome, ferm, str	eet, factory, o	ffice	28f. Loca City	ation (Street and or Town, Stete)	Number or Ru	irel Routa Number,
ely filk	29a. Certifier (Check only		eminer: On the b				he time, date end my opinion, death				
N D	one)					200 1	icanse number		29d. Data	signed (Monti	Day Vest
Med		and title of certifier	Luis	PHYSIC	. ,		1740 (1	med)	MARC	4 29	
completely filled in by the Medical Certifical	29b, Signature	and title of certifier  FLA Spice  ddress of person wh  FIELD S.		se of deeth (Ite	m 23e) (Type,	D3°					2000



State of Maryland / Department of Health and Mental Hygiene

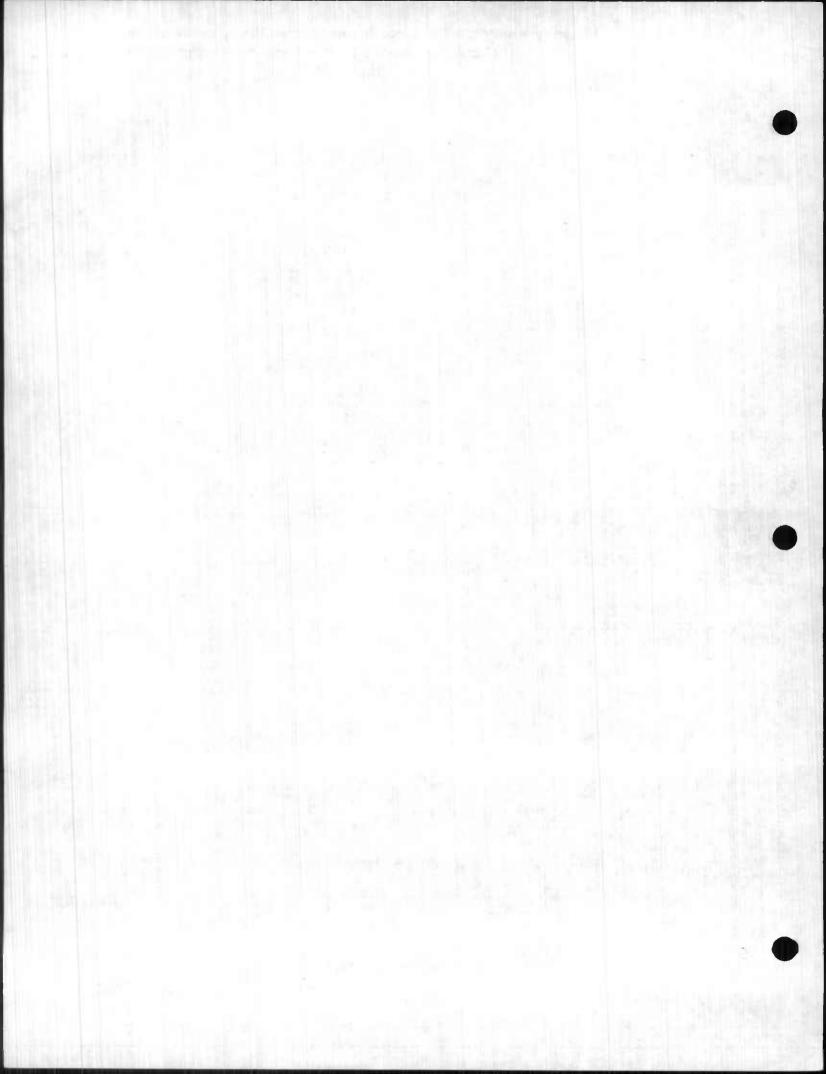
Certificate of Death

Reg. No.

00

11816

ULUL III	1. Decedent's Ner	ne (First, Middle, La	st)					2. Date of D			3. Time of Death
Physician /Medical	T	EZELL	B. SEA	Y				MARCH	26, 20	Yeer 00	2003
/Medical Examiner		(If not institution, giv					4b. City, Tow	n, or Location of Dea		-	
Examiner	SHADY	GROVE A	ADVENTIS	T HOS	PITA	L	ROCKVI	ILLE	MONT	GOME	RY
Funeral	5. Social Security			ige (In yrs. las	t birthdey)	If Under 1 \	reer If Under 2	4 Hrs. 8. Dete of B Min. (Month, D			place (State or Foreign
Director	231-26- Usual Residence	-4446	ПМ 3⁄2 F	75	Yrs.			Dec.2	1,1924	N.	Carolina
tal tal	10a. Stete	10b. County		10c. City, 7						1	0d. Inside City Limits
e Ma	MD	Montg	omery		Rock	ville	:				1 ☐ Yes 2 ☐ No
ar death with the Maryland thems 23a or 21a-f show ner must be notified at uneral Director	10e. Street and No.	<sub>imber</sub> incoln A	venue			10f. Zip Co	0850		U.S.		ntry?
hours after death variety or thems 23 at Examiner must be by Funeral		rried 2 Married	12. Was Decedent Armed Forces 1  Yes, 2  H Yes, Give Year or Dates:	i? No	1	Vas Decedent f Yes, specify I □ Yes 2 🔀	Cuban, Mexicen,	in? (Specify Yes or N Puerto Rican, etc.)	Blac	e - Americ ck, White, Blac	
'natural deted	(Spe	15. Decedent's Ed			16a. Deced	lent's Usuel O	ecupation lone during most etired)	of working	16b. Kind of B	usiness/Ind	dustry
vgiene. er then 'netur r, the Medical Completed	Elementary/Sec 12th		College (1-4or	5+)	<i>III</i> 6. L	Domes	tic			me	
Alental H rhad oth dic even To Be		(First, Middle, Last)						's Name <i>(First, Middl</i> ary Lula			
and Mars as mars aumati		Name/Relationship (			19b. Mailin	a Address (S		r or Rurel Route Num			Code)
27 is 17 is		A. Seay						p Way, B			
tour and	20a. Method of Di			20b. Plac	e of Dispo	sition (Neme	of	Dete	20c. Location -	City or To	own, Slate
ment of ment of mrt. If it ury or o		Cremation 3 5 Other (Specif				netory or othe Litan		. 3/29/0	0 Alex	and	ria, VA
Depart Import any inj ance	21. Significand of F	uneral Service Licer	A118	udo	. 5	SNOWDE	ddress of Facility N FUNE LLE, M	RAL HOME	, P.A.		
Dec 1811	23a. Part1. Enter	the disease, or com	plications that cause	ed the death.				cardiac or respiretory	errest,	1	Approximate Intervat Between
Physician /Medical Examiner	Immediate Cause disease or conditi resulting in death	(Final	0.		PS1:						Onset and Deeth
- T				Due to (or a							
certificate be associed ding physician and use as the burial-transit and a Medical Examin	100		b				r PACE	.500		1	
lan and urial-transit	Sequentially tist of any, leading to it ceuse. Enter Und Cause (Disease of	onditions, immediate lerlying		Due to (or a	s a conseq	uence of):					
attending physician and for use as the bunal-transit clan/Medical Examir	that initisted even resulting in death)	is T	d.	Due to (or es	s e conseq	uence of):					
for us			0							1	
as mat me dea igned by the at be detached fo by Physici	Pert It. Other sign	ificant conditions o	ontributing to death	but not resulti	ng in the u	nderlying ceus	se given in Pert I.		tobacco uee co Yes 2⊠No		the cause of death' bably 4 Unknow
should should	400							24e. Wa	s an autopsy formed?	av	ere autopsy findings allable prior to impletion of ceuse death?
the lay								10	Yes 2 No	1(	Yes 2☑No
	25. Was cese refe	erred to medical					26. Place	of Deeth (Check only			
2 00	examiner?	No	Hospitel: 1 1 Inpat	tient 2 EF	VOutpatien	t 3 DOA	Other:	rsing Home 5 Re		ner (Specil	(y)
ding Phy th.: After this funeral	27. Manner of Dea 1 2 Natural 2 Accident	5 Pending investigation	28a. Date of Inj (Month, D	jury ley Year) 28	Bb. Time of Injury	28c.	tnjury at Work?		how injury occur	red	
tal or Attending P rs after death. el Director: Aftert ed in by the funer: Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place of in	njury - At hometc. (Specify)	e, farm, str	eet, factory, o	ffice	28f. Location City or To	(Street and Numb own, Stele)	ber or Run	el Route Number,
Hospi 4 hour Funer tely fill	29a. Certifier (Check only one)	1 Certifying Ph	ysician: To the best niner: On the basis of and manner s	of examination	dge, death and/or inv	occurred at t restigation, in	he time, date and my opinion, deat	d place, and due to the h occurred et the time	e ceuse(s) and ma e, date end place,	anner es s end due t	stated. the cause(s)
within 2 To the comple	29b. Signature an	d title of certified				29c. L	icense number		29d. Dete signe	d (Month,	Dey, Year)
5	• )	mull	mp.	,		+	15128	50	3-	27-	2000
		iress of person who			3e) (Type,	Print)			r. Ge	rman	20874 town, MD
Chaha	31. Date filed (Mo	iravan I		trar's Signatur							
State Registrar				wa	19.	Spar	K				



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Barbara Jean Sellin 27, 2000 March 12:35pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11215 Lockwood Drive #1511 Silver Spring Montgomery If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (Streta or Country) Feb. 13, 1937 New Jersey 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplace (Steta or Foreign **Funeral** Days 10 M 2 F Hours Months 149 28 1758 63 Director Usual Rasidance of Dacedant the Maryland 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Heidical Examinar must be notified at Montgomery Silver Spring 1 ☐ Yas 2 1 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 20901 USA 11215 Lockwood Drive #1511 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to construent of Health and Mental Hygiena. Important: if Nem 27 is marked other than "natural", or her may linuity or other treumatic event, the Heider Franches 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify: Py 3 ☐ Widowed 4 M Divorced Yaar or Datas: Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 College (1-4or 5+) Vice President of Marketing Banking 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumerna) Be Alice Ledder Joseph Good Sr 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3909 Regal Ct. Virginia Beach, VA 23452 19a. Informant's Name/Ralationship (Type, Print) Joseph S. Good (Brother) 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 3-29-2000 Brentwood, MD Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility ines-Rinaldi 11800 New Hampshire 21. Signature of Funeral Service License Avenue Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List or profile cause on each line. Approximete Intarvat Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Pulmonary emboli Minutes Examiner Due to (or as a consequence of): Examine Right total hip replacement Months Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760 physician that the death certificate be Physician/Medical Dua to (or as a consequence of) 2 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠ Unknown p The law requires 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 s 1 ☐ Yas 2 ☑ No 1 Yas 2 No certificate Division of Vital 25. Was casa rafarred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mennar of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending 1 (Netural 5 Pending 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Director: A completaly filled in by the fu investigetion 2 Accident 6 Could not be determined 3 ☐ Suicida 28e. Plece of Injury - At home, term, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar es stated.

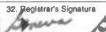
2 Medical Examiner: Or the Dasis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manhar stated. 29a. Cartifiar Medical (Check only one) To the Within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. License number D08089 March 28, 2000

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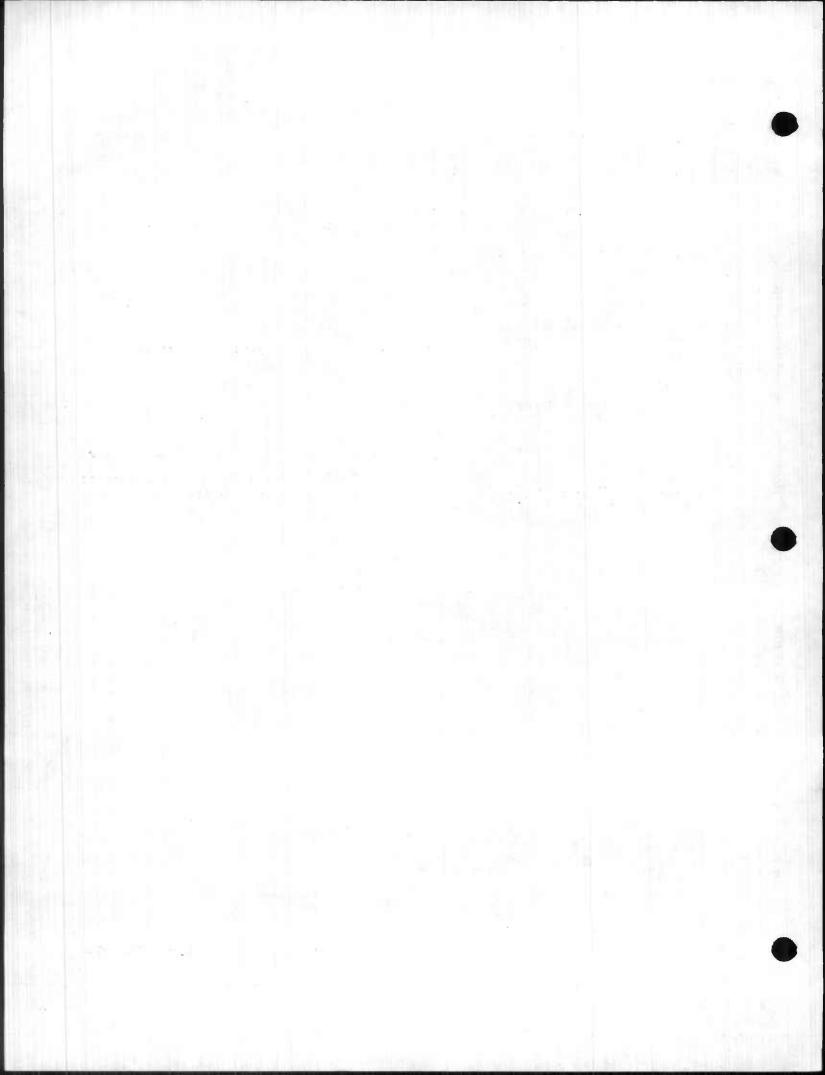
Michael Leibowitz, M.D. State Registrar

31. Data filad (Month, Day, Year) MAR 3 0 2000

30. Nama and address of person whe completed causa of death (Item 23a) (Type, Print)



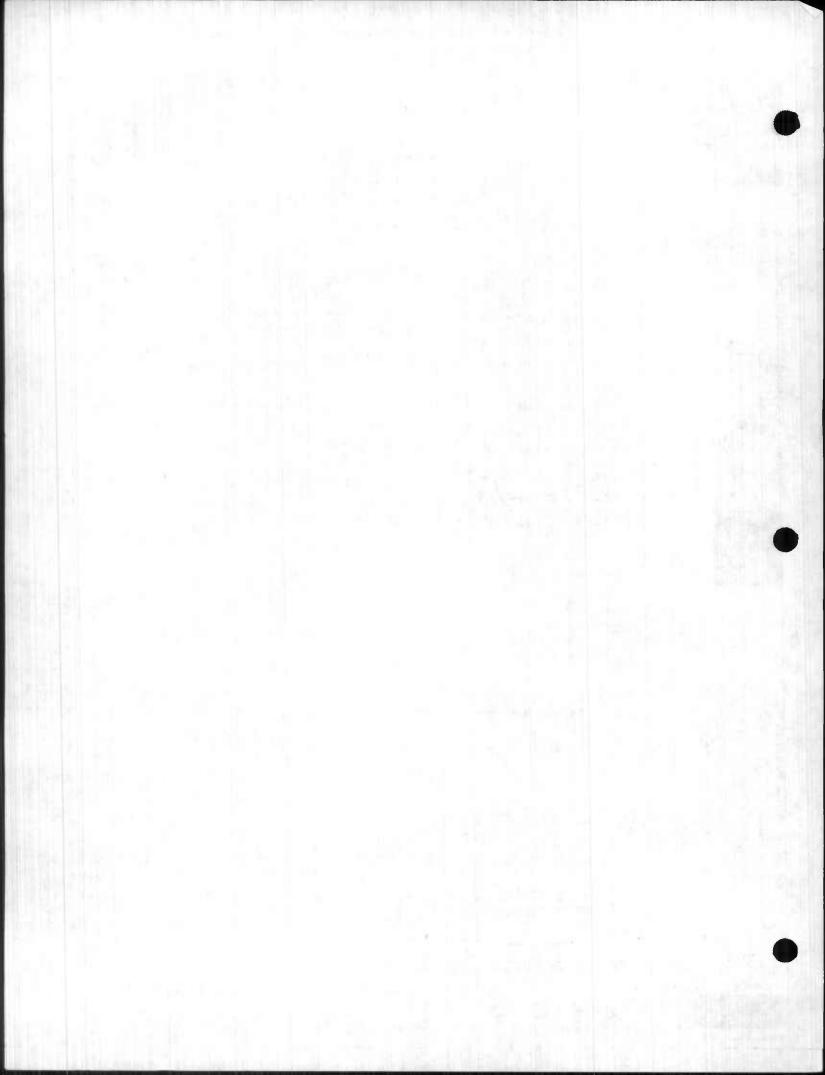
11120 New Hampshire Ave., #305 Silver Spring, MD 20904



State of Maryland / Department of Health and Mental Hygiene 111919

IJ.						Certifica	ate or	Death			Reg. No.		
	1. Decedent's Neme (First, M	iddle, Last	1)							2. Dete of De Month	eth Day	Year 3.	Time of Death
cian	William C. Se	mone	S							March !			16:17
dical iner	4e Facility Name (If not institu	ition, give	street and nun	n <i>ber)</i>				4b. City, To	own, or Lo	ocation of Deat			
	Suburban Hosp	ital						Bet	hesd	la	Mor	ntgomer	V
al	5. Social Security Number	6. Se		7. Age (In )	yrs. last birt		der 1 Year	If Under	24 Hrs.	8. Dete of Bir (Month, Da		9. Birthplece	(State or Foreign
r	232-58-3924 Usuel Residence of Decedent		M 2□F	60	0 )	Yrs. Month	ns Deys	Hours	Min.	December	14,1939	West V	irginia
	10a. State 10b. Cou			10c.	City, Town	or Location						10d.	Inside City Limits
0	Maryland Mon	tgome	3 20 37		Pools	ville							1 X Yes 2 □ No
Director	10e. Streel and Number	egome	-1 y		ROCK		Zip Code				10g. Citizen of	Whet Country?	
	507 Carr Aven	110					209	350			United	Statos	
Funeral	11. Meritel Stetus	1	12. Wes Dece	dent Ever is	n U,S.	13. Wes De			Igin? (Sp	ecity Yes or No Rican, etc.)		ce - American I	ndien,
by	1 Never Merried 2 🗓 N 3 Widowed 4 Divor		Armed For 1 X Yes If Yes, Giv Yeer or De	2□No 1	958 <b>-</b> 1962		pecify Cut 3 2 No			Rican, etc.)	Specif.	ck, White, etc. by: Whit	e
Completed	15. Dece	dent's Edu	cation		16e.	Decedent's U	suel Occu	petion	at of words	ina	16b. Kind of B	Jusiness/Industr	ry
ple	(Specify only high Elementery/Secondary (0-1	-	College (1	-4or 5+)		(Give kind of life. DO NO:	T use retire	during mos	St OF WORK	ing			
no.	12		oonogo (.	10.01,		Sa	lesma	an			Comp	outers	
Be C	17. Fether's Neme (First, Mide	die, Last)						18. Moth	er's Neme	e (First, Middle	, Maiden Surnar	ne)	
10.	William Houst	on Se	emones					Haze	1 Lo	uise Wo	ood		
-	19e. Informent's Name/Releti	onship (T)	ype, Print)		19b.	Melling Addr	ess (Stree	t and Numb	er or Rur	al Route Numb	er, City or Town	, State, Zip Coo	de)
	Suzanne S. Se	mones	s/Wife		50	7 Carr	Aver	nue, R	lockv	ille, N	Maryland	20850	
	20e. Method of Disposition			20	b. Plece of cemeter	Disposition (i	Name of or other pla	ece)	M;	arch 28,	20c. Location	- City or Town,	Sleta
	1 ☐ Burlel 2 ☐ Cremeti 4 ☐ Donetion 5 ☐ Othe			Slete		mery C					Bethesd	la, Mary	yland
	21. Signeture of Funerel Serv	ice Licera	ne of	) 2 M006	72	Rocky Rocky	end Addr	ess of Fecilion Inc.	Nob				ral Home
	shock, or heert feilure.  Immediate Cause (Finel disease or condition resulting in death)	List only o		nary	Embo1	110						On	ervat Between set and Death
7													
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n in		•	<sub>b.</sub> Surgi	cal P	o (or es a c	consequence lure							
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ai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events.	ĺ	b. Surgi	cal P	roced	ure consequence	of):						
Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	{	b. Surgi	cal P	roced	consequence lure	of):						
-	resulting in death) Lest		c	Cal P Due to	roced o (or es e o	consequence conseq	of):						
_	Inat initieted events		c	Cal P Due to	roced o (or es e o	consequence conseq	of):	iven in Pert	t.	23b. Did	tobacco uss co	ontribute to the	e causa of death
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by Physician/M	resulting in death) Lest  Pert II. Other significant cond	itus	cdntributing to de	Oue It	roced roced o (or es e c o (or es e c resulting in	consequence of consequence of consequence of the underlying carcino	of): of):			1 🗆		3 Probable 24b. Were available	autopsy findings ble prior to etion of cause
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DHMH 16 Rev 6/95



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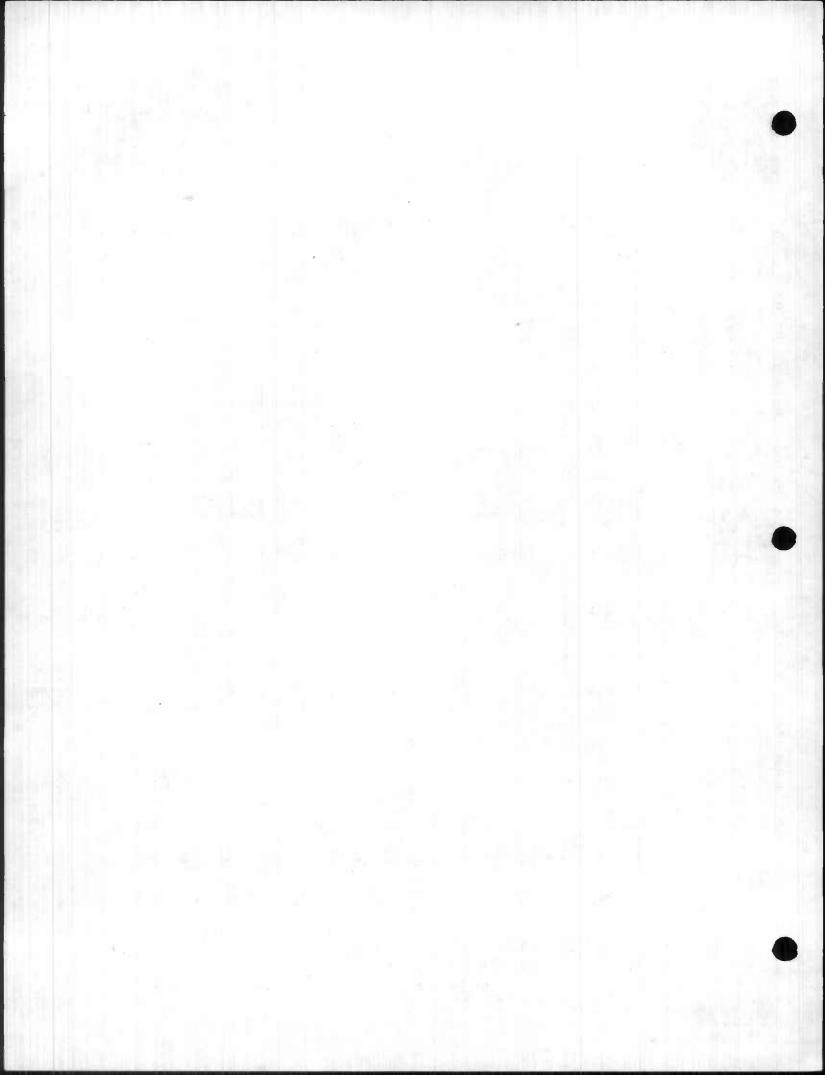
				Certifica	ite of	Dealli		A	eg. No.		
	1. Decedent's Name (First, Middle, L.	ast)						2. Date of Deat Month	h Day	Year	3. Time of Death
cian	Laura Sepul	veda						mouch			2132
lical iner	4e Facility Name (If not institution, gi					4b. City, Tov	wn, or Loc	ation of Death	4c. County		
	SHADY GROVE	E ADVENTI	ST HOE	SITAL		ROCK	VILI	E	LUOM	GOME	RY
1	5. Sociel Security Number 6.	Sex 7. Ag	e (In yrs. last b	irthday) If Und	er 1 Yeer		24 Hrs.	8. Date of Birth (Month, Day,	Vonel	9. Birthpla	ce (State or Foreign
r	216-49-5696	1□M 2ÅF	94	Yrs. Month	s Days	Hours	Min.	Nov. 4,	1905	Porti	uga1
	Usual Residence of Decedent										
	10a. Stete 10b. County		10c. City, Tov	vn or Location						100	d. Inside City Limits
ot o	Maryland Montgom	nery		Rockv	ille						1 ☐Yes 2 ☐ No
Directo	10e. Street and Number			10f. 2	ip Code	Ha Cit		1	0g. CitIzen of V	What Country	y?
	426 Reading Aven	ue		100 mg	2085	0			France		
Funeral	11. Maritel Stetus	12. Wes Decedent	Ever in U,S.	13. Was Dec			gin? (Spec	cify Yes or No- Rican, etc.)	14. Rac	a - American	
2	1 ☐ Never Married 2 ☐ Married	Armed Forces?	No				, Puerto F	ican, etc.)	Blac	ck, White, et	C.
P.	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes	2⊠ No	Specify:			Specify	Whit	te
P	15. Decedent's E	ducation	168	. Decedent's Us	ual Occup	pation			16b. Kind of B	usiness/Indu	stry
Completed	(Specify only highest gr Elementary/Secondary (0-12)			(Give kind of a life. DO NOT	vork done use retire	during most d)	of workin	9			
E	12	College (1-4or !		omemake	r				Own H	lome	
	17. Father's Name (First, Middle, Las	()		20-11		18. Mothe	r's Name	(First, Middle, I	Maiden Suman	10)	
o Be	Edouardo Pereir	a			4	Ant	onia	DoCarm	0		
-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Addre	ss /Street	and Numbe	r or Rural	Route Number	. City or Town.	State. Zip C	Code)
	Laurette Belcher			26 Read							
-	20e. Method of Disposition	Daugneel	20b. Place	of Disposition (A	ame of		1	Date	20c. Location -	-	
	1 ☐ Buriai 2 ☐ Cremetion 3 [		cemet	ery, crematory o	other pla			ar. 29,			
1	4 Donation 5 Other (Speci	**	Montgo	mery Crem					Bethesd		
	21. Signature of Funeral Servica Lice	ensee		Rober Rober	and Addre	Pumph	rey 1	Funeral	Home/R	ockvi	lle, Inc
	Kart Fa	~	M0019	8 300 W	est M	lontgo	mery	Avenue	2805		
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do	not enter the m	ode of dyir	ng, such es	cardiac or	respiratory arr	est,		Approximate nterval Between
	SHOOK, OF Healt landre. List Only	y one cause on each ii	10,								Onset end Deeth
1	Immediate Cause (Final	Cida	. (	dia	Dea	th-					a mit.
	disease or condition resulting in death)	a. Sudd	en co	VALIAC	000					1 /	ninaus
وَ		Munc	ardial	Inhar		153				1 4	dans
直	Commented to the search of the	b. 11900		consequence o		1					anys
Examiner	if any, leading to immediate		Due 10 (0) as a	Consequence o	.,.						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C	Dua to /or oo o		Λ.						
Medicai	resulting In death) Last		Due to (or es a	consequence of	):						
3		d									
- E	ME TO THE COMM										
Physician	Part If. Other significant conditions	contributing to death b	ut not resulting	in the underlying	cause giv	ven in Part I.					he causs of death
4								1 U Y	ss 2 No	3 Probe	bly 4)() Unknow
by										I	
B								24a. Was a perior	n autopsy med?	avail	e autopsy findings lable prior to pletion of cause
9											eath?
100								1 U Y	es 2 No	10	Yes 2 No
mo l						26. Place	of Death	(Check only or	ne)		
e Completed	25. Was case referred to medical				Oth Oth	her:		ne 5 Reside		er (Specify)	
9	25. Was case referred to medical examiner?	Hospital:	ot 2 FRIC	utnationt 31 1	JON	4 140			ow Injury occur		
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death	28a. Date of fniu	ry 28b.	Time of	28c. Inju	ry at	2	cod. Describe n			
To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b.		28c. Injui Wor	ryat rk? !Yes 2⊡!		od. Describe n	,,		
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ledical Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Autural 2  Accident 3  Suicide 4  Homicide  29a. Certifler (Check only one)	28a. Date of Inju (Month, Da ) 28a. Place of Inju (Month, Da ) 28a. Place of Inju building, etc.	ury - At home, 1 c. (Specify) of my knowledge examination s	Time of fnjury M  arm, street, factore, death occurrend/or investigetie	ory, office	me, date and	No 2	28f. Location (S City or Town and due to the could at the time, d	treet and Numb n, State) ause(s) and ma ate and place,	anner as sta end due to t	ted. he cause(s)
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State of Maryland / Department of Health and Mental Hygiene

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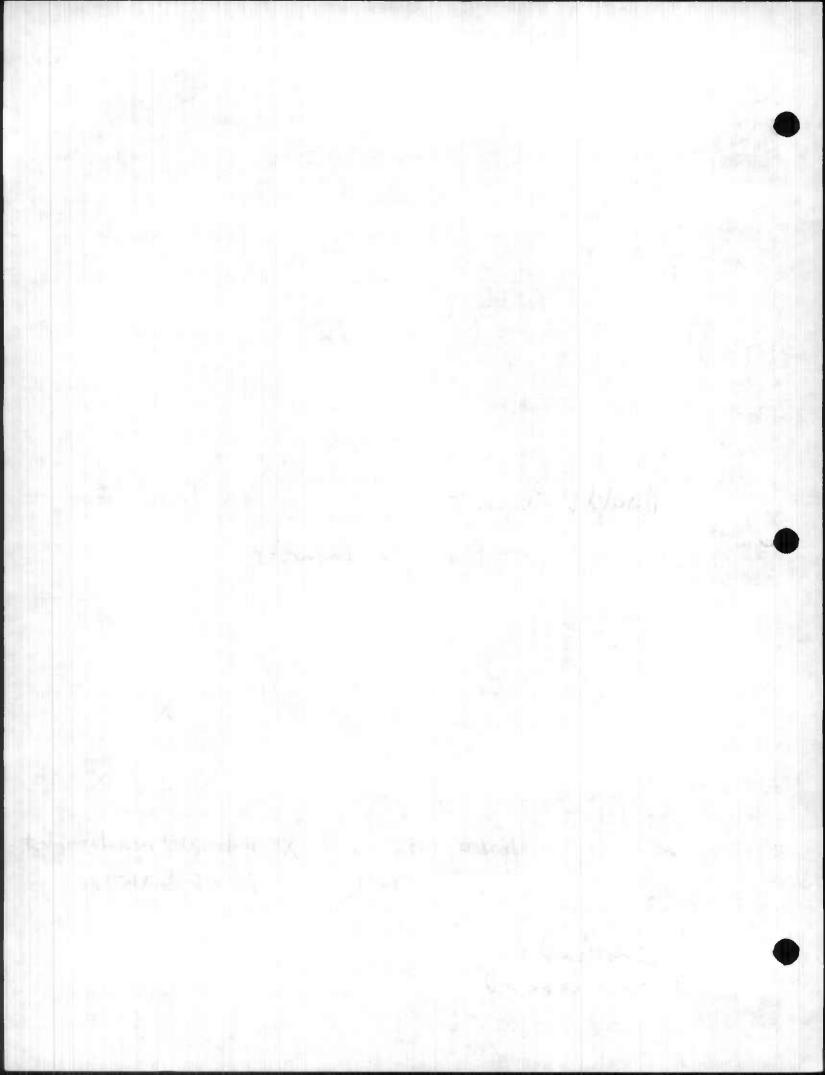
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			Ce	rtificate of	Death		Reg. No.				
	1. Decedent's Name (First, Middle, Las		. Time of Death								
Physician	Tean 5 So	Month	Day Year								
/Medical	4e Facility Name (If not institution, give	street and number)			4b City Town o	r Location of Deat	h 4c. County	and Dooth	11.0011		
Examiner											
	Wilson Health Car							tgomery			
Funeral	5. Sociel Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days		(Month De	V YARE	9. Birthplace	e (Stete or Foreign		
Director	578-44-0567	□M 2只F	85 Yrs.	Working Cuyo	110010	Sept 4	, 1914	Pennsy	lvania		
	Usual Residence of Decedent										
r 28a-f ahow noor and at	10a. Stete 10b. County	100	. City, Town or Lo	ocation				10d.	tnside City Limits		
- 0	Maryland Montgome	orv	Gaithers	hura					1□ Yes 2□ No		
free must be notice. Funeral Director	10e. Street and Number	-17	darthers	101. Zip Code			10g. Citizen of	What Country?	Δ		
							rog. Chazeri or	Title Country			
1 2	8129 Langport Ter	rrace			877			d State			
e	11. Meritei Stetus	12. Was Decedent Ever Armed Forces?	in U,S. 13.	Wes Decedent of I- If Yes, specify Cub-	Hispanic Origin? (	Specify Yes or No		ce - American I ck, White, etc.			
	1 Never Merried 2 Married	1 ☐ Yes 2 ☐ No		1□Yes 2☑No							
þ	3 Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:		TLI 195 ZIXINO	Specify.		Specif	Whi	te		
Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usuai Occup	pation		16b. Kind of B	usiness/Indust	try		
o e	(Specify only highest gra-		(Give	kind of work done DO NOT use retire	during most of w d)	orking	Unit	ed Stat	AC		
Ĕ	Eiamantery/Secondery (0-12)	College (1-4or 5+)	Cler	k / Typis	ct			ir Forc	_		
Ö	17. Father's Neme (First, Middle, Last)		OTEL	K / Typi:		ame (First, Middle					
Be					TO, MOUTHER STATE	anie (i iisi, ieiicole	, water ourse	rray			
P	Francis SI	nerlock			Mary	Kathe	rine	Kinne	у		
	19e. intorment's Neme/Reletionship (7	ype, Print)	19b. Maili	ng Addrass (Street	and Number or F	Rural Route Numb	er, City or Town	, Stete, Zip Co	de)		
To	William J. Seubert	son Son	8129	Langport	Terrace	. Gaith	ersburg	, MD 2	20877		
	20a. Method of Disposition	•	b. Piece of Dispo			Dete 20c. Location - City or Town, State					
5	1 Buriai 2 Cremetion 3 🗆		Mar 29,								
any injury o	4 Dopation 5 Other (Specify			Heaven Co		2000	Silver	Spring,	Maryland		
any in	21. Signature of Funanti Service Licen	196	22	2. Nama and Addra	ass of Facility	DeVo	1 Funera	al Home			
9 8	1 tenu h	Air	10	E. Deer	Park Dr				20877		
	23a Fartt Enter the diverse, or comp shock, or heert fellure. List only	plications thet caused the							proximata		
	shock, or heert fellure. List only	tnt	arvai Between set and Deeth								
ian	Immediate Court (Final	Λ .	,		100						
cal ner	disease or condition a Aspiration Pneumonia.								Ihr.		
ш.	resulting in deeth)	Due	to (or as a consec						THE EAST OF		
Examiner	In FOUR THE STATE OF	Alzho	imer	- dia	ease.			2	ovears		
Ē	Sequentially list conditions.  Due to (or es e consequence of):								J		
X	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or es e consequence of):  Pay Linsons  Due to (or es e consequence of):								1.00.00		
	Cause (Disease or injury	c. tay kir	120112	UISEA	150			) )	years.		
edical	rasulting in death) Last	Due t	to (or es e conseq	uence of):				- 1	0		
Me		4						i			
		u									
0	Pert II. Other etgnificant conditions co	entributing to death but not	uting to death but not rasulting in the underlying causa given in Part i.					23b. Did tobacco use contribute to the cause of death?			
Completed by Physician	Distal in	offil					~				
0	Vialletes Me	21HUS.				.   '	Yes 2 No 3 Probably 4 Unkno				
ð						64. 111		24h Wass	autoney tindings		
te e	CONGONTINO	nouv+ to	21/11/10	,			an autopsy ormed?	availal	autopsy tindings ble prior to		
Pie		· VCu i de	,,,,,,,					of dea	letion of cause ith?		
E	OStonovasio					10	Yes 2 No	1 D Y	es 20 No		
	OS WON ON O				44 7:			101	34,00		
Be	25. Wes case reterred to medical exeminer?	Hospital:		10	hor h	eeth (Check only					
P	TU Yes ZAINO	Hospitel: 1 Inpatient	2 ER/Outpatier	IT 3LI DOA		Home 5 Resi					
	27. Menner of Death	28a. Dete of Injury (Month, Day Yea	28b. Time of	28c. tnju	ry et rk?	28d. Describe	how injury occur	rred			
芸	1 Netural 5 Pending 2 Accident investigation		, argury		Yes 2 □ No						
100	3 ☐ Suicide 6 ☐ Could not be	28a. Place of Injury -	28f. Location (Street end Number or Rural Route Number,								
Certification:	4 Homicide datermined	building, atc. (Sp	ecify)	,,		City or To	wn, Stata)				
Ö											
edicai	29a. Cartifiar 1 Certifying Phy (Check only 2 Medical Exam	raician: To the best of my Iner: On the basis of axan	knowledge, death	occurred et the til	ma, data and place	ce, end due to the	cause(s) end m	annar as state	od. e cause(s)		
B	one)	end mennar steted.		- congation, army c	-printerly death occ	at ura tirria,	Jana and prace,	and due to the			
Medical Certifical	29b. Signature and title of certifier			29c. Licens	se number		29d. Dete signe	ed (Month, Day	v, Year)		
(2)	IN IN	$m \cap$		mo	117791		7/72	o Cond			
2)	1- 100	"", U		11.	7 1/15		0/20	SKO CO.			
	30. Name and address of person who d	completed causa of death	(item 23a) (Type,	Print)	111.00		0.0	70			
	Karen Kabin W	10 301 K	Ussel A	ve va	HNEVSb	erg M(	1 208	1++			
State	31. Dete tiled (Month, Dey, Yeer)	32. Registrer's S	ignature			)					
	188D 9 0 20	III As	1 10			~					



State of Maryland / Department of Health and Mental Hygiene 11821

Physical December 1 As a Party Name of prior in Institution, you should supply a state and number of the Party Name of prior in Institution, you should not should be a compared to the Country of December 1 As a				C	ertificate of	Death	R	eg. No.	1106.1
# Fastly New Office and Service of combined and the property of Death (Charles)   Study Cape   Death (Charles)   Death (Charles)   Study Cape   Death (Charles)   Study Cape   Death (Charles)   Study Cape   Death (Charles)   Death (Ch	Dhuaisian	The second secon							3. Time of Death
FUNCED							-		
215-39-1949 Nov CIF 21 rs. Mortine Days Mour Displaced Processing Section 19 Control Processing							ocation of Death		
A Sale   10c. Control   10c. Control					Months Days				Birthplace (State or Foreig Country) England
BemarksynSecondary (0-12) College (1-4or 3-1)  Student  Waryland  17. Father Name (First, Mostle, Last)  Walayat H. Shah  18. Mother's Name (First, Mostle, Mastle, Surrame)  Fatima Saida Shah  Walayat H. Shah  18. Mother's Name (First, Mostle, Mastle, Surrame)  Fatima Saida Shah  Walayat H. Shah  19. Mall Sth Street, T1 Laurel, Maryland 20707  20b. Menod of Disposition  Walayat Shape (Donation of Disposition)  Walayat Shape (Donation of Donation of Donat	pu .		100	City Town o	Location				10d Inside City Limit
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Elementary/Secondary (0-12)   College (1-4or 5-1)   Student   Maryland   Ma	72 ho			16a. De	cedent's Usual Occu	pation during most of work	ing T		
17. Father's Name (First, Mindle, Last)   17. Father's Name (First, Mindle, Last)   17. Father's Name (First, Mindle, Manual)   17. Father's Name (First, Mindle, Say)   17. Father's Name (First, Mindle, Manual)   17. Father's Name (First, Mindle, Manual)   17. Father's Name (First, Mindle, Shah)   17. Fat	Men.	Elementary/Secondary (0-12) College (1-4or 5+)				d)			y or
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200 Perfl. Enter the classes, of complications (this caused me destit. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate retirerval Enter (the classes)   Approximate retireval Enter (the classes)   Approximate retirev	Depart Depart Import any Inj pnce.	21. Signature of Funeral Service License	Brankard		Donald V.	Borgward er Mill R	t Funera d. Belts	1 Home,	P.A. Maryland 2076
Part   Committee   Course	200	23a. Pari1. Enter the disease, or compile	ications that caused the d	eath. Do not					Approximate
The street of the second of th	Examiner 2	disease or condition resulting In death)	Due to	(or as a con	sequence ot):	Juria			
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State    State	ned be dete					THE L	101	se Sous ?	- Probably 4 Onkin
25. Was case referred to medical examiner?    State	w require						24e. Wes a perior		completion of cause
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Nother (Specify) SCENE    28. Date of Injury   28b. Time of trijury   28c. Injury at Work?   28d. Describe how injury occurred   1   Natural   1   Natural   1   Natural   2   ER/Outpatient   3   Doa   Other:   4   Nursing Home   5   Residence   6   Nother (Specify) SCENE   28c. Injury at Work?   28d. Describe how injury occurred   1   Natural   2   ER/Outpatient   2   ER/Outpatient   3   Doa   Other:   4   Nursing Home   5   Residence   6   Nother (Specify) SCENE   28c. Injury at Work?   28d. Describe how injury occurred   1   Nother   1   Noth	he le hage age omp						Ber	es 2 No	VYes 2□No
27. Manner of Death   Natural   Natu	en: Titlica	25. Was case referred to medical				26. Place of Dea	th (Check only or	18)	
1   Natural   Scident	lis ce direct		Hospital: 1 ☐ Inpatient 2	ER/Outpa	itient 3 DOA Ot	her: 4 Nursing H	ome 5 Reside	enca 6 Other	(Specify)SCENE
O.C.M.E. MARCH 28, 2000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	g je je		28a. Date of injury Month, Day Year	28b. Tim tnju			28d. Describe h	ow injury occurred	1
O.C.M.E. MARCH 28, 2000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	beath. loc: A the fu	accident investigation	210110		1. 0/0, 50/0, 10 / 10 / 10 / 10 / 10				
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O.C.M.E. MARCH 28, 2000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	t hours of uneral Cely filled	29a, Certifier 1 Certifying Physical Check only 2 Medical Exami					and due to the c		
O.C.M.E. MARCH 28, 2000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	thin 2 the mplet								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		/ N C ( ) 1	)		20.				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	3	30. Name and address of person who or	ompleted cause of death //	tem 23a) (Tv		.M.C.	Įv.	MRCH 20,	2000
State		J- LARUN LOCK	cem)			treet, Ba	ltimore,	Marylar	d 21201
	State Registrar				Anne	1			



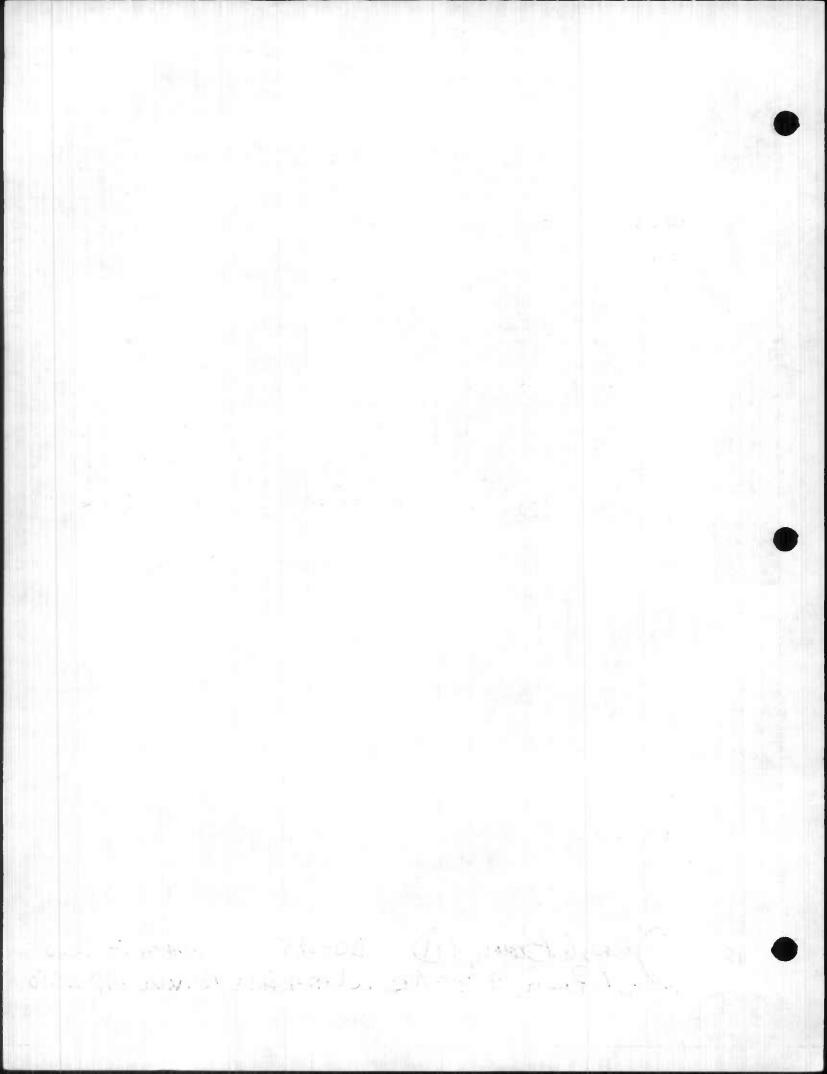
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg No.

				Certifica	ate of	Death		Reg.	No.	1	102	-
	1. Decedent's Nama (First, Middle, La		2. Data of Death Month Day Yaar					. Tima of Des	ath			
Physician /Medical	Richard F. Sherid		4h City Tow	Month Mar	ch 2	7, 2000	1	12:45	ρm			
Examiner	4a Facility Nama (If not institution, given 12600 Farnell Dri							Jeam	4c. County of I			
Funeral Director	5. Social Security Number 6. S		(In yrs. last bir	thday) If Und Month	der 1 Year Days	If Under 2		Birth Day, Ye	Montgo			raign
70	084-24-6817 Usual Residence of Decedent									CW IC	JIK	
Maryler of show	10s. State 10b. County  Maryland Montgome	erv	10c. City, Town		18						Inside City Li	
death with the Maryland rms 23s or 28s-f show rmst be notified at			10g. Citizen of What Country? USA									
5 22 3	11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yas 2 N H Yes, Giva Year or Dates:	0-000	13. Was Dec		Hispanic Origi pan, Mexican, Specify:	n? (Specify Yes of Puerto Rican, ato		14. Race - /	Whita, atc.		
d 2 should be filed within 72 hours aft wand Mental Hygiene. T is marked other than "natural", or traumatic svent, the Hedical Fram To Be Completed by F			16a.	Decedent's Us	sual Occu	pation	of working	16b	. Kind of Busin	ess/Indust	ry	
led within 72 ho yglene. her then "nature it, the Hedical Completed	Elementary/Secondary (0-12)	College (1-4or 5-	1 20	nager	use retire	one during most of working stired)  Finance						
tal Hyg d other Nemt,	17. Father's Nema (First, Middle, Last	18. Mother	s Name (First, Mi									
Mente Mente	Michael Francis S	Sheridan				Thelm	a Smith					
s ma s ma	19a. Informant's Name/Reletionship (	Type, Print)	19b.	Mailing Addre	ess (Stree	t and Number	or Rural Routa N	umber, Cit	ber, City or Town, Steta, Zip Code)			
and	Mary B. Sheridan	/ Wife				Drive	, Silver	7				
Pages 1 mr. if Her my or oth	20a. Mathod ol Disposition  1		cemeter	Disposition (A y, cremetory o wn Memo	r other ple		13/30/0		. Location - City ckville		Stata	
permit. Pages 1 an Department of Heai Important: if liem 2 any injury or other once.	21. Signature of Funeral Service Lico 23a. Part1. Entar the disease, or com	trand	the death. Don	500 U	nive	sity B	ns Funer	Sil		ing,	MD 20	90
Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in death)	a Epidermo	id Carc			ft Alv	eolar Ri	.dge			years	
rificate be executed ng physician and set the buriel-transit												
certificate to nding physic use as the brown try Medica												
deeth certing of for use	Part II. Other significant conditions of	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the cause of de			
es that the deeth ca igned by the attend be detached for us: by Physician/		ic Obstructive Pulmonary Disease							1 Yes 2 No 3 Probebly 4 Unknow			
aw requir										availat	autopsy lindir ble prior to ation of cause th?	
The page								1 🗆 Yas	2X No	1 🗆 Ya	as 21 No	
certificate rector, page 50	25. Was case relarred to medical axaminer?				1.0		of Death (Check o	only one)				
2 2 2	1 ☐ Yes 2 🕅 No	Hospital: 1 Inpatien			DUA		sing Homa 5 🖔			Specify)		
After After fund	27. Manner of Death 1 2Naturat 5 Pending 2 Accident investigatio		Injury   28b. Tima of   28c. Injury at   Work?     1   Yas 2   No			1 2 2 1 1	28d. Describe how injury occurred					
or All	4 Homicide determined	3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, Iarm, street, Iactory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
Ne Hospital n 24 hours in Ne Funeral I pietaly filled	29a. Certifier (Check only one)  1 Certifying Ph	ysician: To the best of niner: On the bests of a and manner stat	axamination and	, death occurre Vor investigation	ed et the to	ima, data end opinion, deeth	place, and due to occurred at the t	the cause ime, date	e(s) end menne and place, and	er es state due to tha	d. a cause(s)	
within 2 To the comple	29b. Signature and titla of certifier	0	1	2	29c. Licen	se number	,	29d.	Data signed (A	Aonth, Day	, Year)	
15	James a.	Brown	MI		DO:	7285		M	BRCH ?	17,	2000	
	OPMES A. BR	completed cause of de	707 N	1601CA	10	ONTER	DRIVE!	640	WILLE,	MD	2081	0
State	31. Data filed (Month, Day, Year)	32. Registra	r's Signatura	1	,							

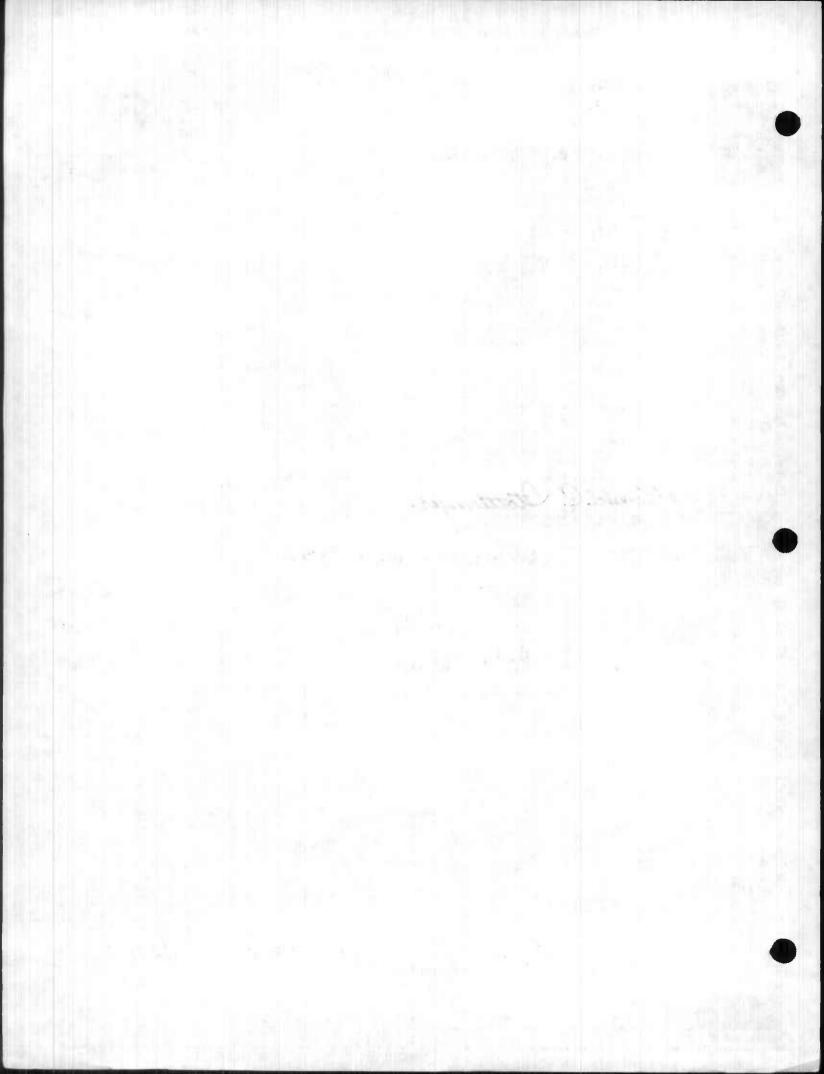
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State of Maryland / Department of Health and Mental Hygiene

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rtificate of	Death		Beg. No.	U

2	ma (First, Middla, La	est)				of De		2. Data of Dea		Year	3. Tima of Death
lical JACK	S.	SILVER						MAR. 2	5, 2000	rear	7:00 AM
iner 4a Facility Nama	(If not Institution, giv SELKIRK D		n		7		City, Town, or Lo SETHESDA	ocation of Death	4c. County MONT	of Death GOMERY	
5. Social Security 579-20-4		Sax 7. A	Aga (In yrs. 76	last birthday) Yrs.	If Undar 1 Y Months D		Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day JUNE 19	Year) 1923	9. Birthplac Country NEW Y	ORK
Usual Rasidance 10a. Stata	of Decedant 10b. County		10c. Cit	y, Town or Loc	cation					10d.	. Insida City Limit
MARYLAND	MARYLAND MONTGOMERY BETHESDA									1 Yas 2 N	
MARYLAND 10e. Street and N 6701	umber SELKIRK D	RIVE			10f. Zip Co 20	da 817			IOg. Citizan of V UNITED		
3 ☐ Widowed	Armed Forcas?  1 Nevar Married 2 Married  3 Widowed 4 Divorced  Armed Forcas?  1 Yas, specify Cuban, Maxican, Puàrlo Rican, atc.)  1 Yas, Specify:					ck, Whita, atc	Amaricen Indian, Whita, atc.  WHITE				
(Sp	15. Decedent's Education ecity only highast grada complatad) condary (0-12)  Collega (1-4or 5+) 5+			16a. Decedent's Usual Oc (Giva kind of work do lifa. DO NOT usa re STATISTICIA		dona during most of working retired)		ing	16b. Kind of Businass/Industry U.S. GOVERNME		
17. Fathar's Nam	A (First, Middla, Last)  1 SILVER	)				18		e (First, Middla,	Maidan Sumam		
F	Name/Ralationship (	Type Print)		19h Mailin	a Address (S			al Routa Numbe		Stata Zip Co	ode)
MIRIAM		(WIFE)								ARYLAND 20817	
20a. Mathod of D	•			Place of Dispos	sition (Nama	of r place)		Data	20c. Location -	City or Town	, Stata
	2 ☐ Cramation 3 ☐ 5 ☐ Othar (Specil		a	LEBANO			Y 3	/27/00	ADELPHI	I, MAR	YLAND
21. Signature of I	21. Signature of Funarel Service Licansee  22. Nama and Addrass of Fecility DANZANSKY—GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE—ROCKVILLE, MAR										
	23a. Part1. Enter the disease, or complications that caused the district Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
disaasa or condit resulting in death	Immediata Causa (Final disaasa or condition resulting in death)  a. Atherosclerofte Iteach Disease.  Dua to (or as a consequence of):										Oyr
Sequentially list of if any, laading to		b. Ascites 3 u								3 wh	
Sequentially list of any, laading to	conditions, Immadiata		Dua to (c	r as a consequ	uance of):					i	,
Causa (Diseasa of that initiated ever	its	c. Penel	c. Lenel Insufficiency  Dua to (or as a consequence of):							(	Cino
rasulting in death	) Last	Arti	0	tenos	1					-	3 .1 =
ary		d. ( )		101103					77.18		945
Part II. Other sign	ificant conditions of	ns contributing to death but not rasulting in tha undartying cause given in Part I.					in Part I.	23b. Did tobacco use contributs to the cause			
by							13.				
Completed								24a. Was a	an autopsy med?	availa	e eutopsy finding: able prior to pletion of causa eth?
CO								101	as all No	101	Yas 2□ No
25. Was casa raf		Hospital:				Other		th (Check only o			
		28e. Data of Ir	ijury	ER/Outpatient 28b. Tima of		Injury at Work?		28d. Dascribe			
27. Manner of De	1 ☑ Natural 5 ☐ Panding (Month, Day Year) Injury 2 ☐ Accident investigation 3 ☐ Sulcida 6 ☐ Could not be datarmined 4 ☐ HomicIda						s 2□No	281. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
-	investigatio	e 28a. Place of	njury - At he atc. (Specif	y)	aat, factory, o		i	City or Tow		nnar as stated.	
27. Manner of De 12 Accident 3 Sulcida 4 Homicida	investigatio  6 Could not be datarmined	28a. Place of building,	atc. (Specified of my known of axamina	y) 	occurred at t	ha tima,	data and place,	end due to the	m, Stata) causa(s) and ma	annar as stat and dua to th	red. na causa(s)
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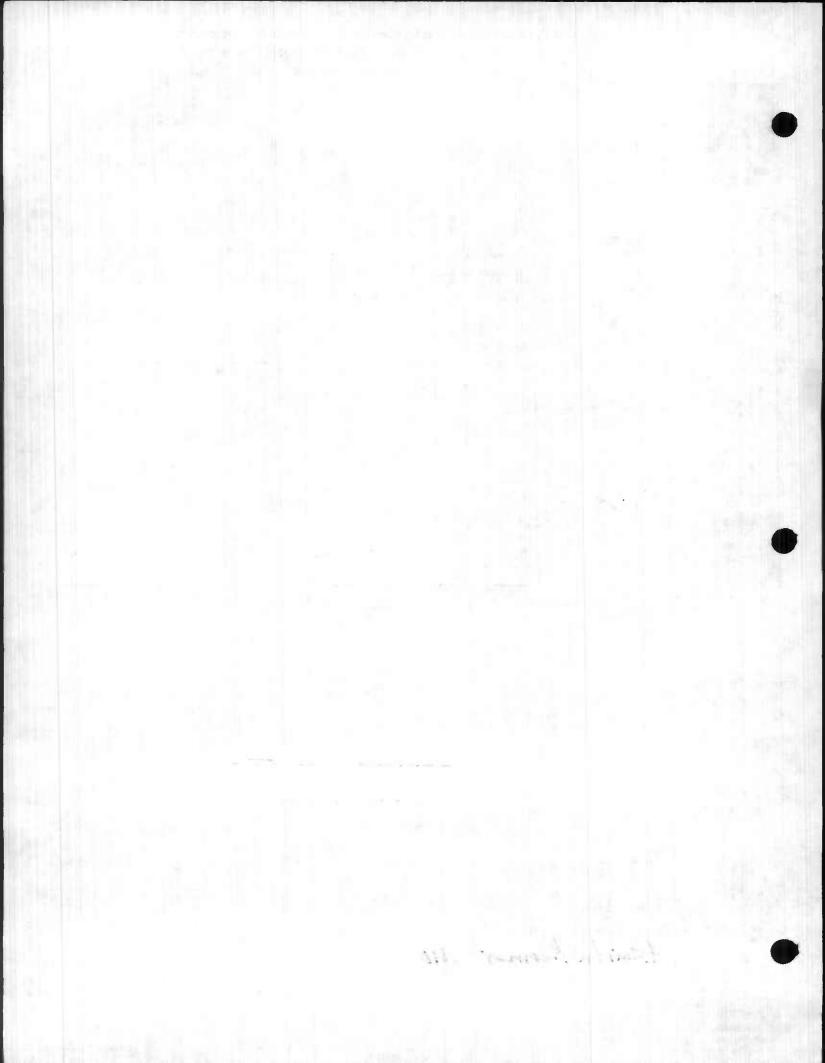


State of Maryland, Department of Health and Mental Hygiene

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AMEND ITEM: #23 PART I, PER MEO G783 5-17-00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 30,2000 8:30 AM Sylvia Luria Silverman March /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 □ F Yrs. **Director** October 30,1912 Maryland 579-62-5755 87 Usual Basidence of Decedant 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MD. Bethesda Directo Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 7420 Westlake Terrace #1008 20817 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married Maryland 21215-0020 1 Yes 2 No Specify: À 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast greda completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry E E Elemantary/Secondary (0-12) College (1-4or 5+) F.B.I. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Mental and 2 should be Rose Meruis Maurice Luria and a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Health hem 27 k 7420 Westlake Terrace # 1008 Bethesda MD. 20817 Louis C. Silverman Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date Pages 1 Burlal 2 Cramation 3 Ramoval from State D 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 4-2-2000 Adelphi MD. 21. Signature of Euneral Service Licenseo 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final Acute Myocardial Infarction Hours disease or condition resulting in death) Examiner Due to (or as a consequence of): COLONARY ARTERY Disease
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Tears or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): and Box 68760. physician Physician/Medical Due to (or as a consequence of) usa as the attending PO detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by of Vital Records, þ should be 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 has 1 Yes 2 No 1 TYAS 2 No this certificate 25. Was casa raferred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred after death. Division Injury 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data end place, and due to the cause(s) and menner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certified D06019 enner March 30,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harris M. Kenner M.D. 5454 Wisconsin Avenue Chevy Chase MD. 20815 32. Registrar's Signature 31. Data filed (Month, Day, Year) State MAR 31 come Registrar

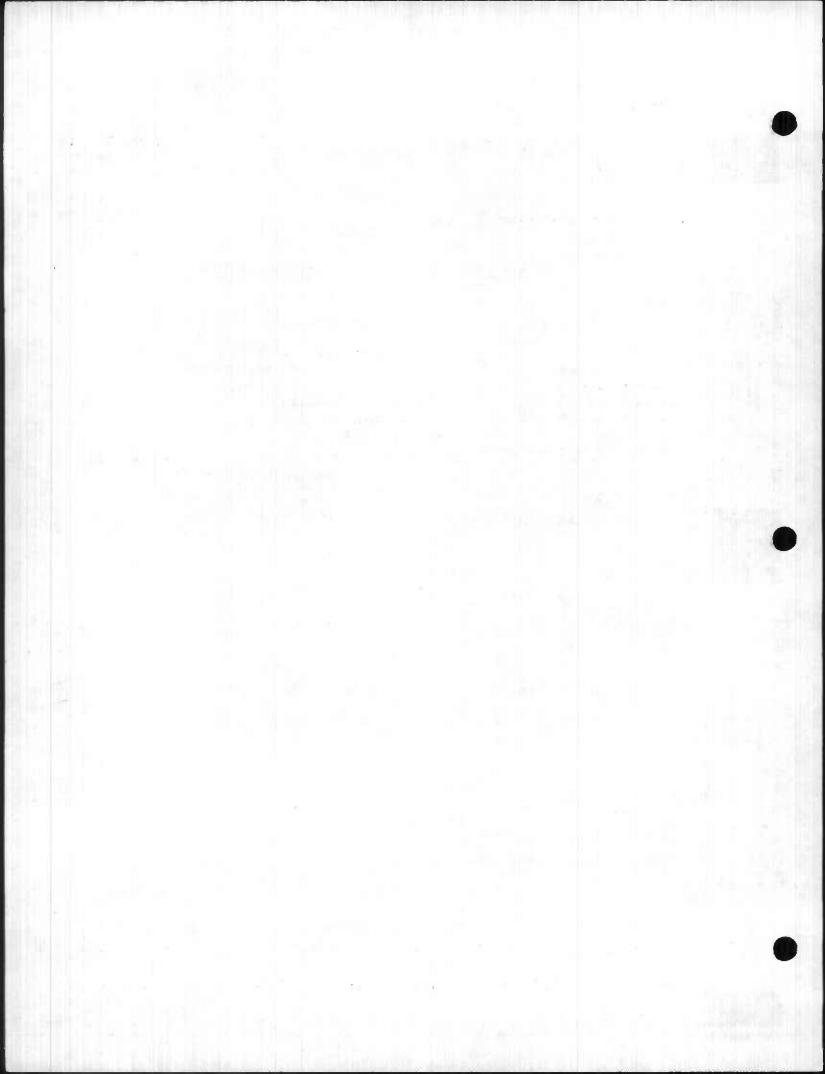


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State of Maryland / Department of Health and Mental Hygiene 00 11825

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Funeral		5. Social Security Number 6. Se		(In yrs. last b	birthday)	If Under 1		If Under 2		8. Date of Birtl (Month, Da)			place (State or	Foreign
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To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	29a. Certifier (Check only (Check only and formation and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and me													
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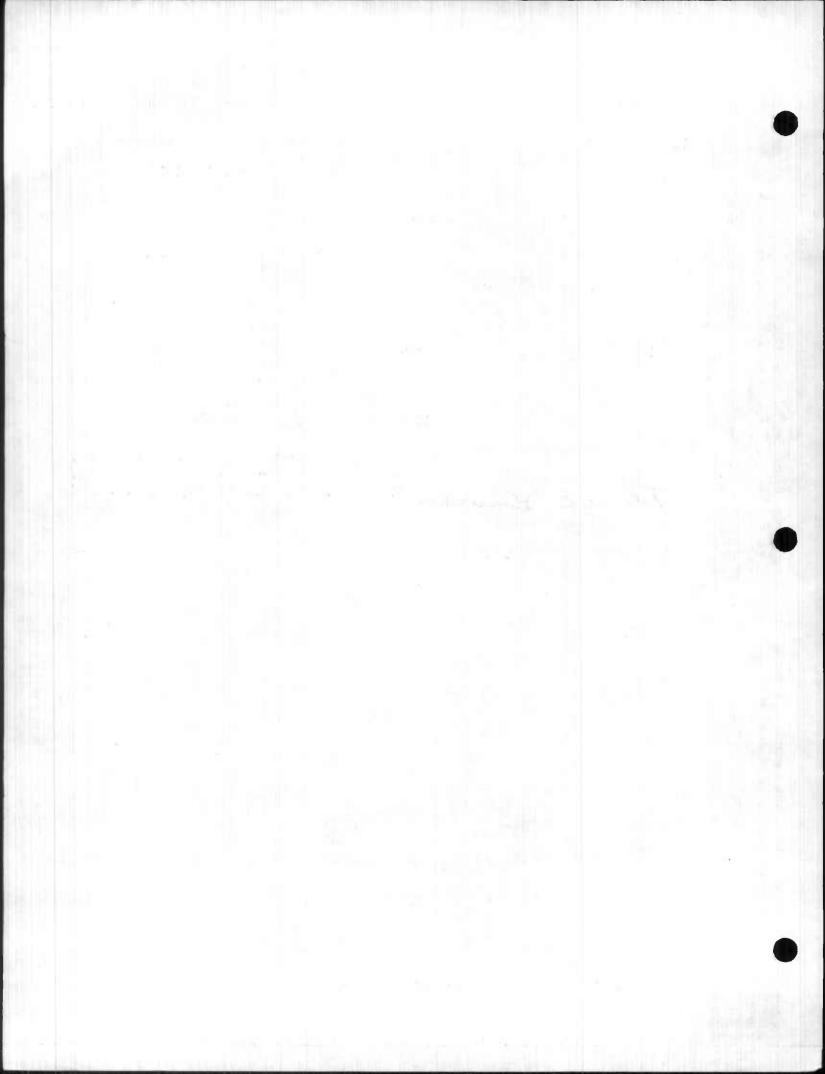


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State of Maryland / Department of Health and Mental Hygiene

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1700 River Road Social Security Number 6. Se 077-56-2835 Sual Rasidence of Decedent Da. State 10b. County	ex 7. Age				4b. City, Town, or	Location of Death	4c. County	of Death	
Social Security Number 6. Se 12. Security Number 1.	TM 2NE						. c. c.c.i.	01 0 0 0 0 0 1 1 1	
Social Security Number 6. Se 12. Security Number 1.	TM 2NE				Potoma	ac	Monts	gomery	V
077-56-2835 sual Rasidence of Decedent Da. Stata 10b. County	M 2LAF 27	(In yrs. last bi	irthday) If Und	ler 1 Year S Days	If Under 24 Hrs Hours Min.	8. Data of Birth			aca (State or F
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	ype, Print)			district the same				State, Zip (	Code)
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	Removal from State	20b. Place o	of Disposition (N ery, crematory or	lame of r other pla	ce)	Data	20c. Location -	City or Tow	vn, State
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Nama and addrass of person who co				u =					
	Specify only highest grater   State   State	15. Decedent's Education   (Specify only highest grade completed)   Elamentary/Secondary (0-12)   College (1-4or 5-12)   College (1-4or	Stroke   S	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Unite. DO NOT Homemake (Specify only highest grade completed)   16b. Do NOT Homemake (Specify only highest grade completed)   17. Fishar's Nama (First, Middle, Last)   19b. Mailing Address   1700 Riv   10b. Mailing Address   170	15. Decedent's Education   16. Decedent's Usual Occur, (Give kind of work done life. DO NOT use refere Homemaker   12.   12.   12.   13.   14.   14.   15.	15. Decedent's Esucation   15. Decedent's Esucation   15. Decedent's Decedent's Usual Cocupation   15. Decedent   15. Decedent	15. Decedent's Education   (Speetly only highest grade completed)   16a. Decedent's Usual Occupation   (Speetly only highest grade completed)   17. Fether's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother	Stroke   S	Stroke   S



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1827. Certificate of Death 1. Decedent's Neme (First, Middia, Last) 2. Data of Death Day Month Year James Robert Swann March 28. 2000 6:00 PM 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 5. Social Security Number Sex M 2□F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State py Coveign Country) Days Hours Min. Months 578-42-9495 68 December 17,1931 Washington Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3581 Port Tobacco Road 20662 USA 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yas 2 No 1950 -1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 1952 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Federal Govt 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Roy Swann Frances Hudson Swann 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Rye/Daughter 9260 Tayloes Neck Rd. Nanjemoy, MD.20662 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Nanjemoy Baptist 4/1/00 Nanjemoy, MD. 21. Signature of Funeral Service Licensee M00945 AREHART - ECHOLS FUNERAL HOME, P.A. cchi 0. 567 LA PLATA, MD. BOX 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown carcinoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 12 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

ö Division Attending 8

Physician/Medical þ Completed Be Medical Certification: To after deatl Director: To the Hospital within 24 hours a To the Funeral D

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

"natural", or items 23a or 28a-f

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any injury or other traumatic event aloss.

**Physician** 

/Medical Examiner

Examiner

72 hours after

altimore, Maryland 21215-0020

Director

Funeral

ğ

Completed

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27. Manner of Death

29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and little of partition 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christian Hansen, M.D. 701 Fast Charles Street P.O. Box 1070 LaPlata, MD 20646 31. Data filed (Month, Dey, Year) 32. Registrer's Signeture

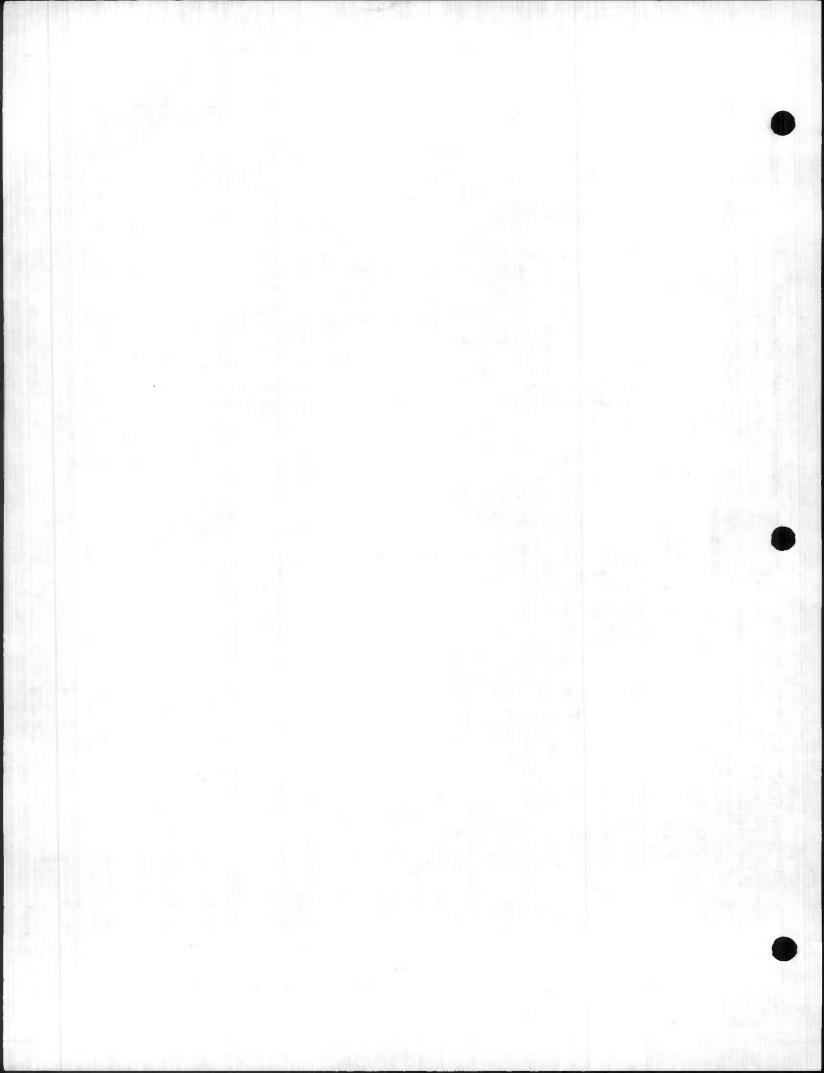
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#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** Year Thomas Scott Smith, Jr. March 27 2000 7:09pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Pay, Year) May 11, 1928 Birthplace (State or Foreign Country) Mary land 7. Age (In yrs. last birthday) **Funeral** Deys Hours 10 N 2 F 216-22-1478 Yes Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show 1 Tyes 2XXNo Maryland Charles Director Naniemov 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9050 Riverside Road 20662 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Raca - American Indian, Bleck, White, etc. 1 Nevar Marriad 2 Married 1 ☑ Yes 2 □ No It Yes, Give Korean Year or Detes: 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) US Government Civil Engineer 10 poemit. Pages 1 and 2 should be fits. Department of Health and Mental Hy, important if hem 27 is meried other any Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Thomas S. Smith, Sr. Rosie Gue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sandra/A.) Smith=Daughter 9062 McRae Ct., Manassas, VA 20110 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Doration 1 Other Maryland Veterans' Cem. 4-4-00 Cheltenham, MD Mark G. 21. Sign , 22. Name and Address of Fecility Huntt Funeral Home M00053 P. O. Box 156, Waldorf, MD 20604-0156 Brohawn 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onsat and Death **Physician** CARDIAC ARRHYTHMIA Immediate Cause (Final disaase or condition resulting in death) /Medical Examiner Due to (or es a consequence of) CARDIO MYDPATHY attending physician and for use es the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): SCHEMIC HEART Physician/Medicai Due to (or as e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco vae contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en autopsy 2 X No 1 Yes 1 □ Yes 2 □ No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 10 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? edical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifler

Division of Vital

P.O. Box 68760.

Records,

D-50350 03/27 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Frank L. Kriger M.D., 7C Post Office Road, Waldorf, Maryland 20602 31. Date filed (Month, Dey, Year)

State Registrar

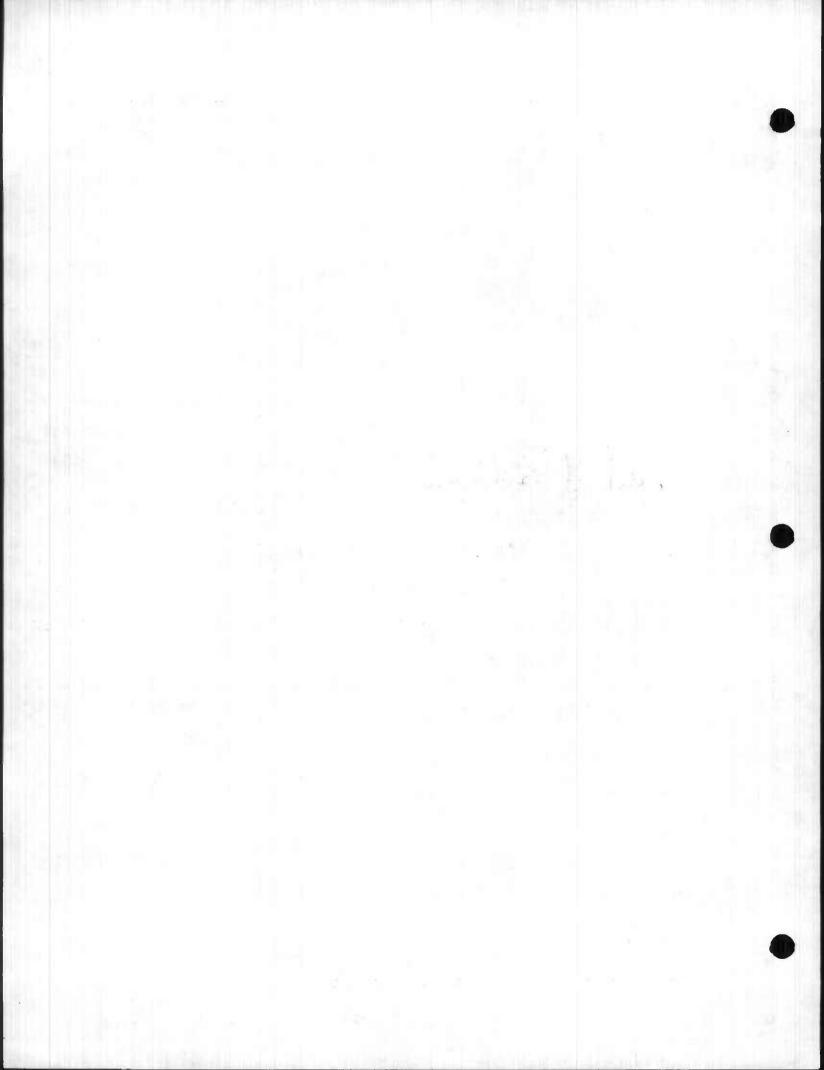
MAR 3 1

29b. Signeture and title of certifier



29c. License number

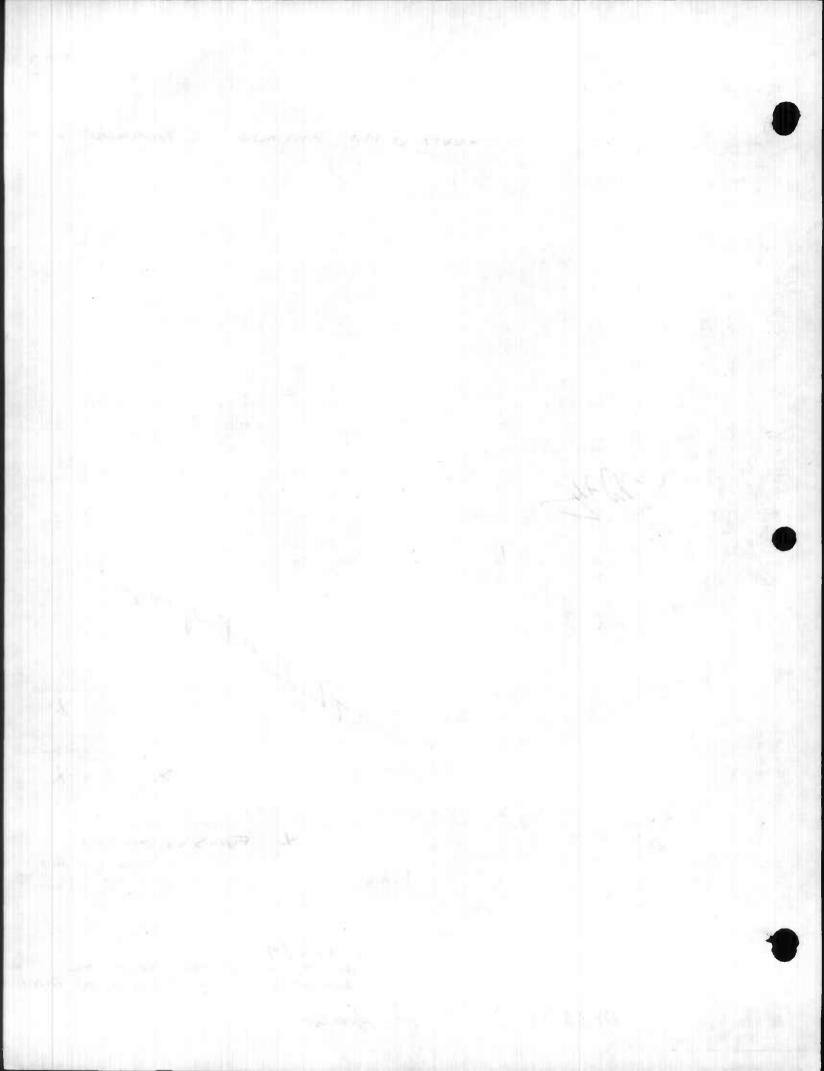
29d, Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Glenn Saylor 25 00 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MTIS trauma - UNIV OF MD BAUTIMORG BAUTIMORES Shock Hours Min. 8. Date of Birth (Month, Day, Year) 8 / 1 7 / 1 9 2 6 ff Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND 6 Sax **Funeral** 1⊠M 2□ F 73 215-20-8399 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo CARROLL FINKSBURG 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? mast be n 4600 SYKESVILLE RD. 21048 USA #117 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Yeer or Detes: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Merried 2 Married 8 Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced WHITE TT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry ot of Health and Mental Hygiene.
If New 27 is marked other Buor other trause. Elementary/Secondary (0-12) College (1-4or 5+) 12 CONSTRUCTION CARPENTER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE HERMAN SAYLOR VIRGIE DAVIS Pages 1 and 2 should 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE C. SAYLOR -WIFE 555A HAMMERSTONE DR., WESTMINSTER, MD.21157 altimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/28/00 SMALLWOOD, MD. DEER PARK CEMETERY 21. Signature of Fure a Service Licensee 22. Name end Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on aech line. Approximate fnterval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Mily June Physician/Medical Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760. the Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No Hematoma p 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: funeral director, 8 25. Was case referred to medicat 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Menner of Death 28a. Date of Injury (Mgnth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending Investigation after death. Director: Af 1 Yes 2 DINO FOUND UNCONSCIOUS UNK. 2 Accident 116100 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 4600 Sikes Ville Rd Lot#117 21049 home Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29e. Certifler (Check only one) To the I 29b. Signeture end title of certilies 29c. License number 29d. Date signed (Month, Day, Year) OF 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) UNIVERSITY ma HOSPITAL 225. GREEN Clark BAITIMORE, MD Stock 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar MAR 2 8 2000

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death BRH Amend item#19a 4/1/00 HCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, JOHN A. SWAILES March 2000 09=45 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Harford 4206 Conowingo Rd., Lot #1 Darlington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) XXM 2 F 203-10-6145 89 12/26/1910 Maryland 10c City Town or Location 10b County 10d Inside City Limits Harford Darlington 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4206 Conowingo Rd., Lot # 1 21034 USA 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes a No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 Specify: SpeWhite 3CWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Mill worker Manufacturing 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Lest) William . George Swailes Anna Pearl Deck 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 207 High St., Hagerstown, MD 21740 Florence L. House-daughter 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Harford Mem. Gardens 3/17/2000 5 Other (Specify) Aberdeen, MD 21. Signature of Funeral Servica L 22. Name and Address of Facility 600 MAin St., Harkins F.H.Inc., Delta, PA nt. Enter the disease, or concations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 17314 Approximate Interval Between Onset and Death Immediate Cause (Final HASCYD disease or condition resulting in death) Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

Examiner

Physician/Medicai

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Completed

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Certification:

Medical

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**Physician** 

/Medical

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Funeral

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**Funeral** 

Director

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exams on must be notified as

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiena. Important: If item 27 is merked other than "natural", or han any Injury or other traument.

Baltimore, Maryland 21215-0020

the Marylend

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ician and burial-trans the se esn 0 signed by the e page 2 s certificate

funaral director,

Hospital or Attanding Physician: 24 hours after death. Funeral Director: Attar this certifice To the Hospital or Attain within 24 hours aftar der To the Funeral Director completaly filled in by the

P.O. Box 68760.

Division of Vital Records,

1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 No Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dev. Year) 29b. Signature and title of certifier

Daye 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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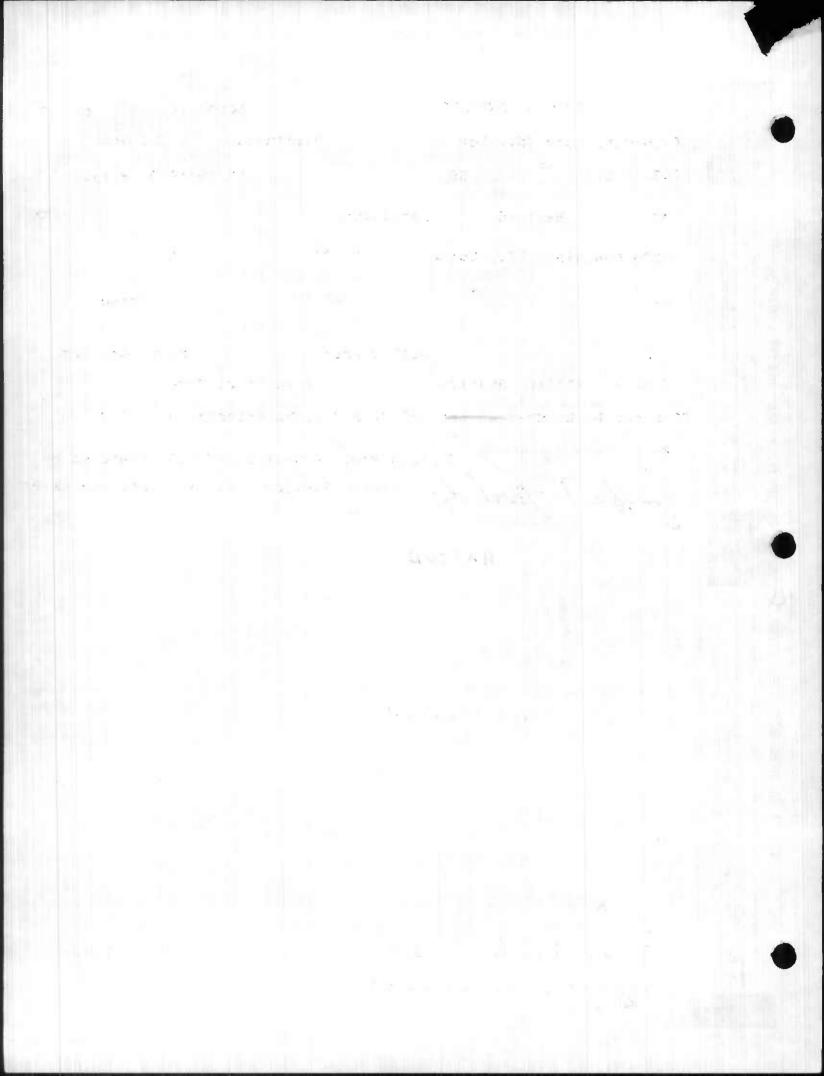
31. Date filed WAR Day, Bed 2000

BEZAIN MO 21014 728 BKL AIN Registrar's Signature

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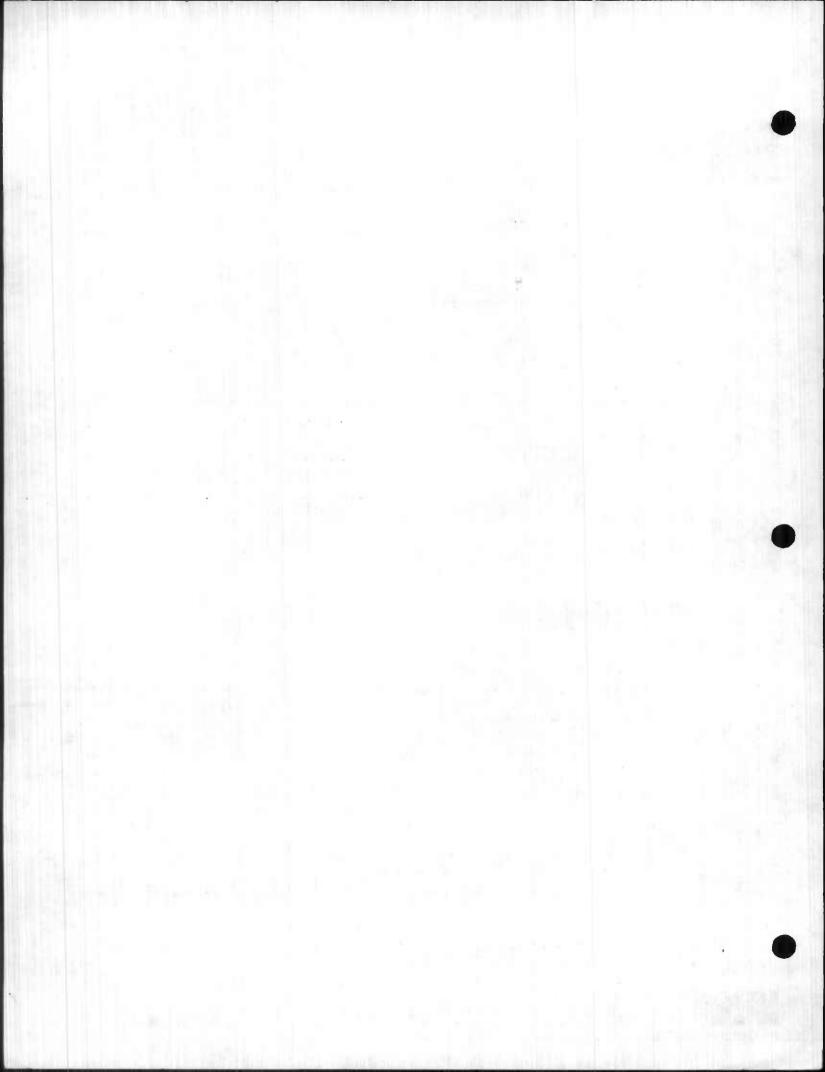
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State Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Mariner Healt  5. Social Security Number	6. S		7. Aga (In yrs	last hirthday	) If Unde	r 1 Year	Kensi If Under					mery 9 Birtholac	e (State or Foreign
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	12				Assi	stant	Man				Drug			
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I	Aaron James !	Cangy	e					Eva	S. S	ingleta	arv			
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resshock, in heart failure. List only one cause on each line.												i Ar	proximale
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State of Maryland / Department of Health and Mental Hygiene

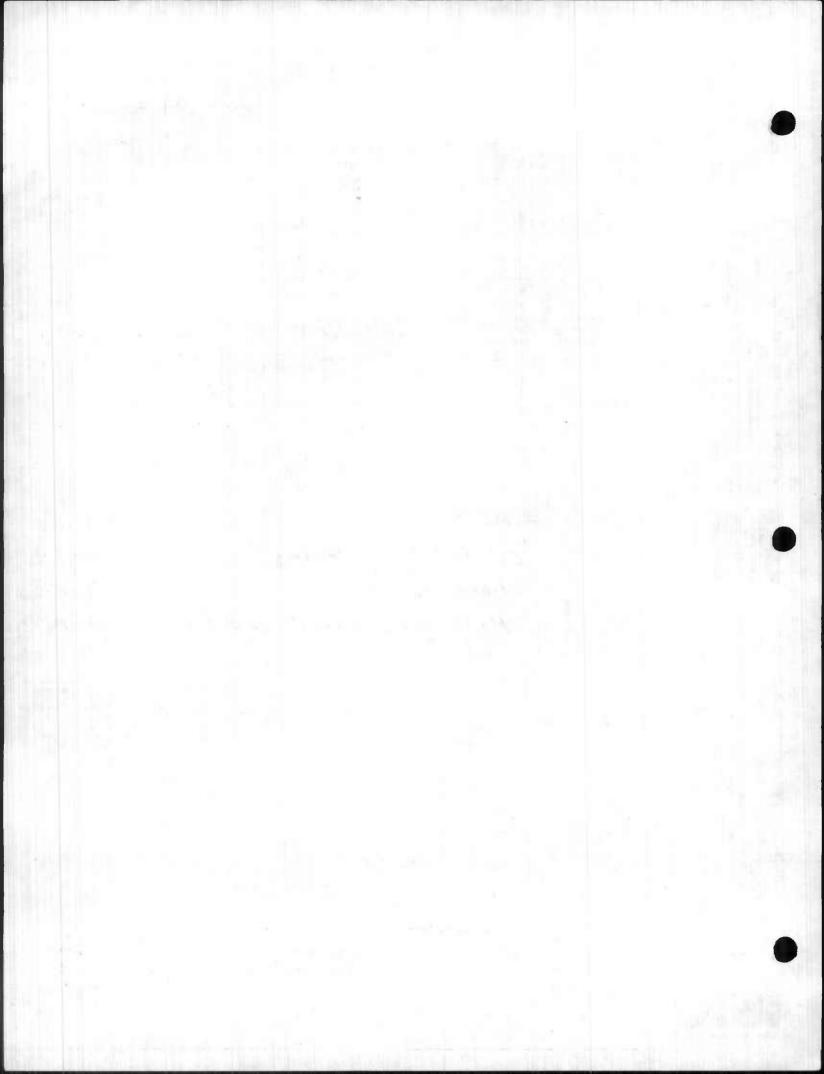
Certificate of Death

11832

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:15PV MARCH 2000 Christine Sue Taylor /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□ M 2 F Director 220-60-5151 January 24, 1952 Ohio Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Poolesville Maryland Montgomery 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23e or 20873 Funeral 14821 Sugarland Road United States 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status filed within 72 hours after 1 Never Married 2 ☐ Married b 1 ☐ Yes 2 ☑ No Specify: 21215-0020 Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Institute American Hygieno. ther then Elementery/Secondary (0-12) College (1-4or 5+) of Architecture Accountant aftimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be fit iment of Health and Mental H tant: If them 27 is marked off Be Nancy Parks Robert Jameson Taylor 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Department of Health a Important: If them 27 is any injury or other trau 9827 Belhaven Road Bethesda, Maryland 20817-1731 Nancy Taylor/ Mother 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 1 Buriel 2 □ Cramation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 28,2000 Rockville, Maryland Robert A. Pumphrey Funeral Home/
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase 1nc 37557 Wisconsin Avenue
M00335Bethesda, Maryland 20814-3501 21. Signeture of Funeral Service Licenses MUU335|Bethesda, Maryland 20014-5503

23a. Pert1. Enter the disaasa, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel Miliopulmersmy diseese or condition resulting in death) **Examiner** The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last monn Box 68760 1ettsATIC 2451 Physician/Medical 94 Due to (or as a consequence of) signed by the atte 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 0 1 Yes 2 No 3 Probably 4 Unknown 9 Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 2/2 No certificate 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Inpatient 2 ER/Outpetient 3 DOA this 27. Manger of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After ! 1 ☑ Neturel 2 ☐ Accident 5 Pending 1 Yes 2 No 24 hours after death. investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

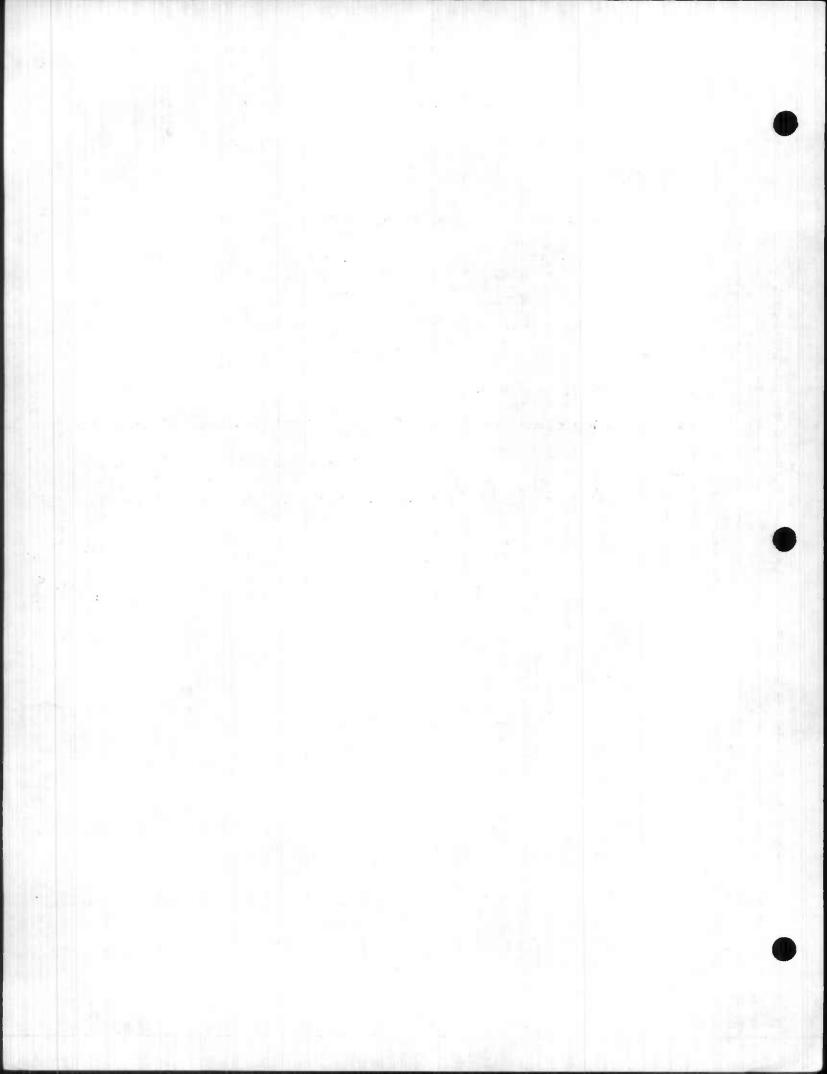
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier completely (Check only one) To the To the To the F WATCHER M. (1) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50h2 53177 JULY WALLMARK 9707 Medius Center DR., Rickville, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State oaks 2000 Registrar



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	4. Decedently Man	- Fina Adidde A	-41		Certificate	of Death		Reg. No.	1 1 0 0 0	5
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- 1	5. Social Security	ederick R		Age (In yrs. last bir	thday) If Under 1	Gaither			Comery  Ritholaca (State or Fore	reion
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her death v here death v finer mast	11. Meritel Stetus		12. Was Deceder Armed Force	s?	13. Was Deceder If Yes, specify	it of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- American Indien, White, etc.	
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DHMH 16 Rev 6/95



Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 24, W. 2000 10:50 PM TOMPKINS MARION /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□ M 2₩ F 577-50-6830 68 Director Oct. 24, 1931 Wash. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahore the Medical Examiner must be notified at 1 Yes 21 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 531 Randolph Road, #331 20904 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 Specify: Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ginns Office Supply 12th Supervisor Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 end 2 should be fil ment of Health and Mental H lant: If itam 27 la merked off jury or other traumatic avan Be Andrew Warfield Eleanor Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13200 Sandston Cr., Laurel, MD 20708 Sarita A. Milliner (Dau.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State **Department** 4 ☐ Donation 5 ☐ Other (Specify) 3/31/00 Silver Spring, MD Gate of Heaven Cem. 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Liganian Rou ROCKVILLE, MD 20850 23s. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Cardiopulmonary arrest Examiner Due to (or as a consequence of): fibrosis Examiner idipathic pulmonary hysician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 USB P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary artery Division of Vitai Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed breast carcinoma 1 Yes 2 No 1 EYes 2 □ No diabetes mellitus or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 100 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Wedical 29a. Certifier completely

0

State Registrar

31. Date filed (Month, Day, Year) MAR 29 2000

Gynthia Craufald-Breen, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifier

Cynthia Crawford-Green, M.D. 32. Registrar's Signature

1175 Belle Point Dr., Greenbelt, MD oouter

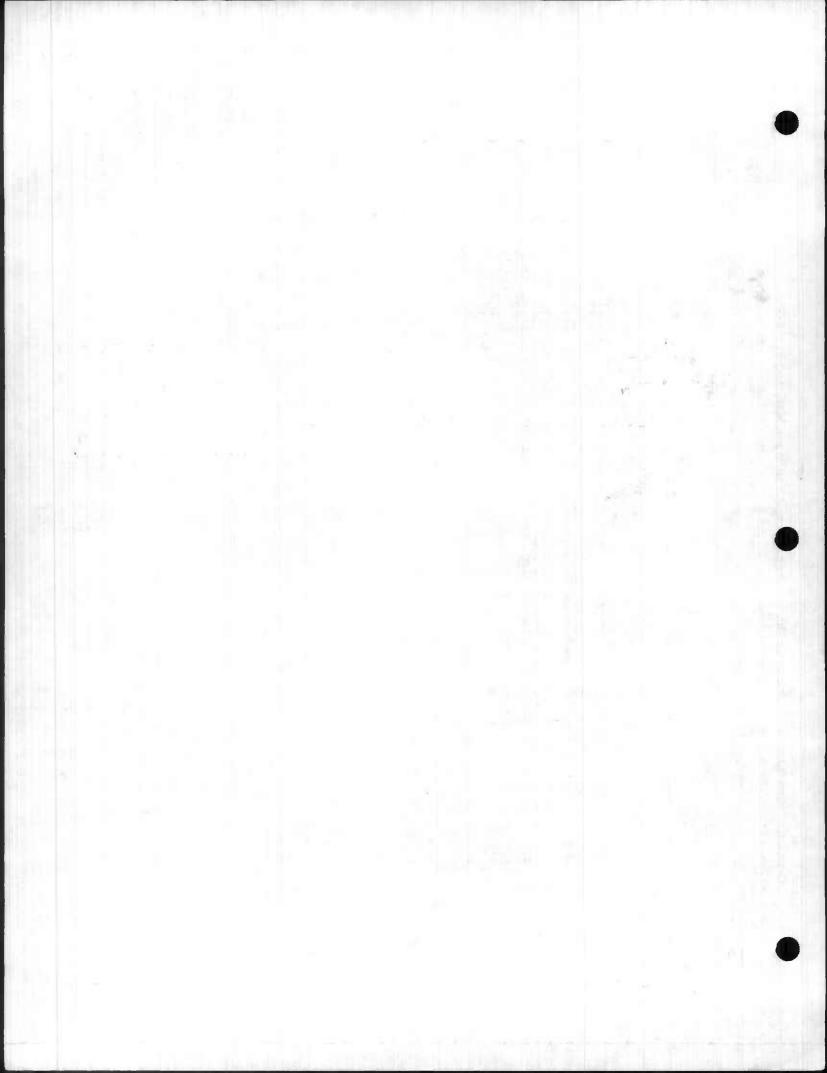
29c. License number

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29d. Date signed (Month, Day, Year)

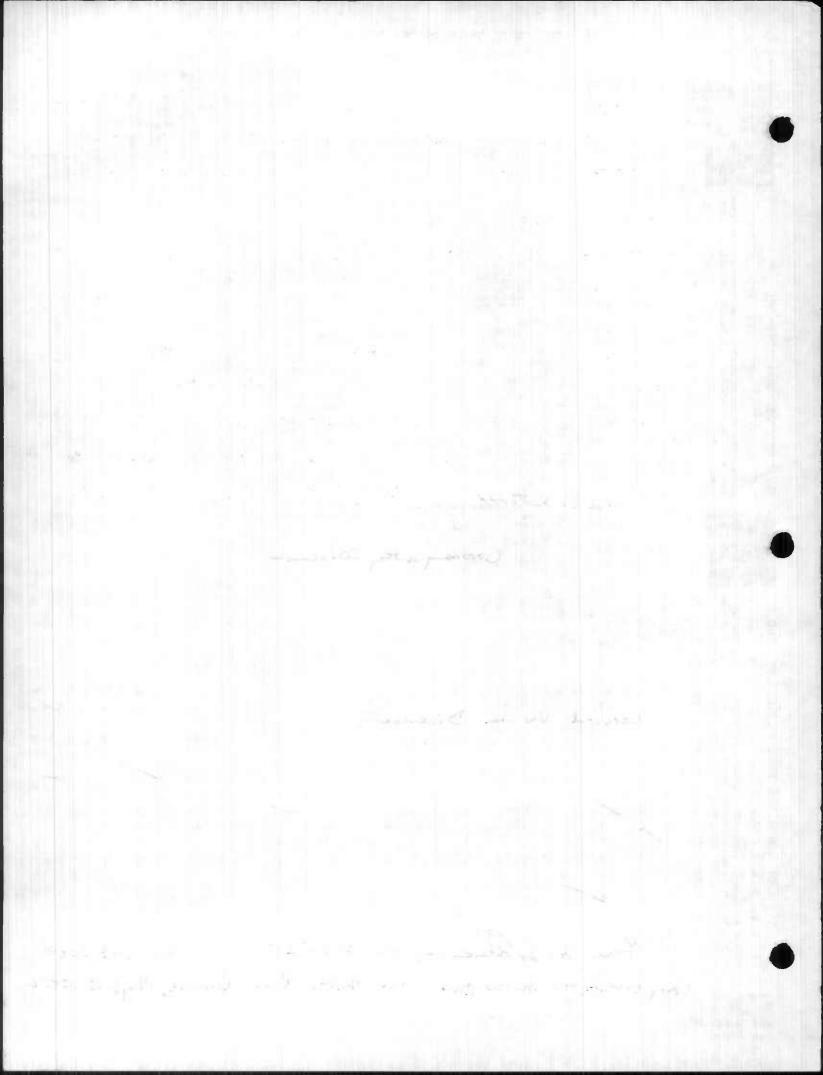
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					Certi	ificate of	Death			Reg. No.		
		1. Decedent'a Name (First, Middle, L.	ast)						2. Date of De	eath Day	Voor	3. Time of Death
Physicia /Medic		ROSE TWORECK	Ε						MARCH	26, 200	Year	10:00 P.M
Examin	_	4a Facility Name (If not institution, gi							cation of Deet			
		Hebrew Home	of Greater	Washing				vill			gome	ry
Funeral Director			Sex 7. Ag	e (In yrs. lest bii 87		If Under 1 Year Months Deys		24 Hrs. Min.	8. Dete of Bi (Month, Di May 5,	rth ay, <i>Year)</i> 1912	9. Birthi Cour Po1	plece (State or Foreign ntry) and
/lend		10e. Stete 10b. County		10c. City, Tow	n or Loca	tion						10d. Inside City Limits
he Man	ector	Florida Palm B	each	Boca	Rato					40- 00	4/h - A C	XXYes 2 □ No
eth with the Marylen 23a or 28a-f ahow	Funeral Director	10e. Street and Number 4024 Wolverton B	(Century	Village	1	10f. Zip Code 33434				U. S.	Α.	
or freme	by	11. Marital Status  1 ☐ Never Married XX Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces?  1  Yes 2 Tr  If Yes, Give Year or Detes:		H Y	as Decedent of es, specify Cul	oen, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)		ck, White,	can Indian, etc. hite
72 hours	Completed	15. Decadent's E (Specify only highest gi	ducation	16e	(Give kir	nt'a Usual Occu	durina mosi	t of workin	na	16b. Kind of B	usiness/în	dustry
	nple	Elementery/Secondery (0-12)	College (1-4or 5	5+)	life. DC	NOT use retin	ed)	o works	.9	0 7		
	S	12 Years		H	ouse	wife				Own I		
40 0 - 0 -	0	17. Father's Name (First, Middle, Las Efraim Lewis	1)					r's Name 1asch		, <i>Maid</i> en Suman known)	16)	
should have		19a. Informant's Name/Relationship	(Type, Print)	198	. Meiling	Address (Stree	t and Numbe	er or Rura	l Route Numb	er, City or Town,	Stete, Zij	o Code)
≥ 5 ± 2 ± .		Frank Tworecke	- Son	1	1102	Hidden	Trail	Dri	ve, Ow	ings Mil	lls,	Md. 21117
altimore, Marylar mit. Pages 1 end 2 should be periment of Heelth end Menia portant: If Item 27 ie marked. y Injury or other traumatic ev cs.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec		cemete	ry, crema	tion (Neme of tony or other plo rael Co		28/2	Dete	20c. Location -		own, State w York 125
Baltimo permit. Pages Depertment of Important: If I any Injury or pages.		21. Signature of Funeral Service Lice		Aguda	22.1	Name end Addr	ess of Fecilit	v				
W FOEE 8		Donald C	States		DAN:	ZANSKY- O Rocky	GOLDBE	ERG M	EMORIA Rocky	L CHAPEI	is, I	nd 20852
Physician /Medical Examiner	Jer	23e. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting In death)		Due to (or es a	enter	Die	seess					Approximate Interval Between Onset and Deeth
x 6876( artificate be ing physicia e as the buri	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting In death) Last	c	Due to (or as a								
Box death ce	Icla	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the und	erlying cause o	iven in Pert I		23b. Did	tobacco use co	ntribute t	o the cause of death?
P.O. hat the deteched	Physician/									l Yes 2□ No	3 Pro	
COC required	Completed by								24a. Wes	s en eutopsy omed?	CC	fere autopsy findings veileble prior to ompletion of cause deeth?
I Rec	E								10	Yes 2 No	1	☐Yea 2☐No
Vital	Bec	25. Wes case referred to medical					26. Place	of Deeth	(Check only	one)		
of Vita Physician: this certific ral director,	10	examiner?	Hospital: 1 Inpatie	ent 2 ER/O	utpatient	3 DOA	ther: 4 No	irsing Hor	ne 5 Res	Idenca 6 🗆 Oth	er (Speci	fy)
On O ding Ph h. After th funeral								g Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
Division  (or Attending after deeth.  Director: After d in by the fune	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)  28f. Location (Street and City or Town, Stete)									ber or Rur	al Route Number,
Hospit 4 hour Funer taly fill	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.										atated. to the cause(s)	
within 2 To the	29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month									Dey, Year)		
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		30. Neme and eddress of berson who B. Wilks MS 31. Date liled (Month, Day, Year)	Hebrew H		(Type, Pr	Ment	se Ro	pal	Rock.	ilk M.	ny lan	, 2000 d 20852
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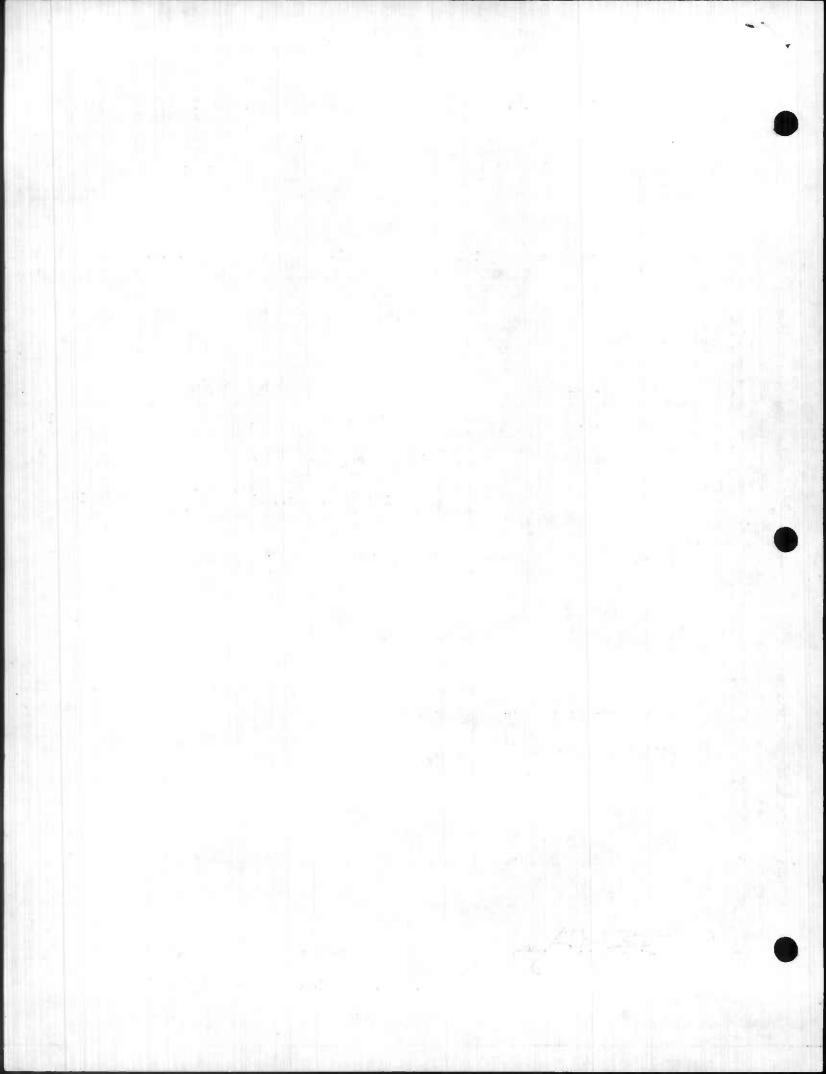
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State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtificat	e of	Death		Reg. No.	0 1	1000
	1. Decedent's Name (First, Middle, L.	ast)	ALL					2. Date of De Month		Yaar	3. Time of Death
sician ledical	CHARLES	R.M.	TUTTL	E				March	16, 200	0	5:30AM
niner	4a Facility Nama (If not institution, g	ive street and numb	er)				4b. City, Town, or	Location of Deat	4c. Coun	ty of Death	
	Maplewood Health	Care Cer	nter				Bethesda	1	Mont	gomer	У
	5. Social Security Number 6. 578-32-7647 Usual Residence of Decedent	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. 96	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.		th ry, Year) 1903	Coun	place (State or Foreign ntry) away, NJ
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
io	Maryland Montgo	merv	Be	thesda							1 ☐ Yes 2X No
Directo	10e. Street and Number	Juic Ly	1 20	circoaa	10f. Zip	Code			10g. Citizen of	What Cour	ntry?
	9707 Old Georgeto	own Road	#1212		20	814			U.S.A.		
by Funeral	11. Marital Status  1 □ Never Married 2☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Yaar or Date	s? No				dispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)		ice - Amaric ack, White, i/y:Whit	etc.
Completed	15. Decedent's E (Specify only highest p			16a. Dece	dent's Usua	af Occup	pation	drina	16b. Kind of	Business/Inc	dustry
ple	Elementery/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	se retire	during most of word)	inery	4000		
Con		5+		Engi	neer				Engine	ering	
Be	17. Fathar's Nama (First, Middle, Las	t)					18. Mother's Nar	me (First, Middle	, Maiden Sume	me)	
2	Joseph F. Tutt	:le					Susa	an Hoagl	and		
	19a. Informant's Name/Ralationship	(Type, Print)			-		and Number or Re				
	Samuel S.D. Ma	arsh, Att	orney	7700	01d G	Geor	getown Ro	1., #800	Bethe	sda,	MD 20814
	20e. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of		20b. Find of	Place of Disponentery cree rst Pre Rockay	esition (Name to the start of or	ne of other ple eria emet	cery Church	Date 3/29/00	20c. Location		
any injury or ance.	21. Signature of Funaral Service Lice	kuton		22 J	Name an	d Addre	WLER'S SO . Ave., 1	ONS, INC		DC 2	20016
edical Examiner	disease or condition resulting in death)	a. Arter		or es a consec		IIaI	Disease			1	20 years
edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c		or as a conseq							
	resulting in death) Lest	d								1	145
<u><u>C</u></u>	Part ff. Other significant conditions	contributing to deat	h but not res	ulting In the u	nderlying c	ause gi	ven in Part I.	23b. Did	tobacco use c	ontribute to	o the cause of death?
by Physician/M	Pelvic Fracture						1.45	10	Yea 2□No	3 Pro	bably 42 Unknown
Completed	Atrial Fibrilla	tion						24a. Was perfo	an autopsy omed?	SV CO	ere autopsy findings railable prior to empletion of cause death?
E								10	Yes 210 No	10	□Yes 2□ No
BeC	25. Was case referred to medical				-1-1		26. Place of De	eth (Check only			
To Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3□ DC	Ot Ot	hae	forme 5□Resi		ther (Specif	(N)
	27. Manner of Death 1 ☑ Netural 5 ☐ Panding	28a. Date of I (Month,		28b. Time o Injury	2	8c. Inju Wo	ry at	1	how injury occi		,,
Certification:	2 Accident investigetie 3 Suicide 6 Could not 4 Homicide determiner	28e. Place of	M 1 Yes 2 No					al Route Number,			
Medical Certification: 1	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	st of my kno s of examina stated.	rred et the time, date and place, and due to the cause(s) and manner as stated. ation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)			itated. o the cause(s)					
×	29b. Signature and little of certifier				290	. Licens	se number		29d. Data sign	ed (Month,	Day, Year)
	THE THE	ant.		D42423 March 28, 2000					000		
	30. Nama and address of horse who Robert B. Mozaye			isc. Av		NTJ di	1455	Chevy Cl	nase. M	0 208	15
State	31. Date filed (Month, Day, Year)		strar's Signa		/E + 5 1	F4.84 - 1/	エインン	Olicvy Ol	idoe, il	200.	
State	MAR 2.9 2	nnn le	were	19	do	2. 11	1				

DHMH 16 Rev 6/95



# Allison W. Thomas Baltimore, Maryland 21215-0020

		Total y lain		ificate			Mental Hy	Reg. No.	0	11837			
1. Decedent's Neme (First, Middle	, Last)						2. Date of Dea Month	eth Day	Year	3. Time of Death			
ALLISON WILMER	THOMAS						March	31 2	2000	7:40 pm			
4a Facility Name (If not institution		ber)					Location of Death		ty of Death				
Civista Medical C				Williadand		Plata		Char					
5. Social Security Number  218-07-0312  Usual Residence of Decedent	6. Sex 7.	. Age (In yrs. I	Yrs.	If Under 1 Months		Under 24 Hrs lours Min.		(. Year)	9. Birth Col MAR	nplaca (State or Foreign Intry) YLAND			
10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits			
MARYLAND CH	ARLES	T.A	PLATA							1 ☐ Yes 2 No			
10e. Street and Number			2 22 -321	10f. Zip C	ode			10g. Citizen o	What Cou	untry?			
7779 BUMPY OAK	ROAD			20	646			UNITE	STAT	TES			
11. Maritat Status	12. Was Deced	ent Ever in U.	S. 13. W	as Deceder	nt of Hispar	nic Origin? (S	pecify Yes or No- to Rican, etc.) 14. Race - Ar Black, W						
1 Never Merried 2 Marri	Armed Force of 1 Yes 2 if Yes, Give	No		□Yes 28	The same of	pecify:	Constitu						
3	Year or Date								. DIX	ACK			
15. Decedent (Specify only highes	's Educetion it grade completed)		16a. Decede	int's Usual ( ind of work O NOT use	done durin	n ng most of wo	rking	CHARLE					
Elementary/Secondery (0-12) 7TH GRADE	College (1-4	lor 5+)	CUSTO		311100)		CHARLES			DUCATION			
7. Father's Name (First, Middle,	Last)				18.	. Mother's Na	me (First, Middle,						
NATHAN THOMAS					H	ESTER !	THOMPSON	THOMAS	5				
19a. Informant's Name/Relations	nlp (Type, Print)		19b. Mailing	Address (S	Street and i	Number or R	ural Route Numbe	er, City or Tow	n, State, Zi	ip Code)			
PORTIA MILES /	E, MARY	LAND	20774										
		0					Date	20c. Location	- City or T	Town, State			
	©Burial 2 Cremetion 3 Removal from State   Cemetery, cremetory or other place)												
4 Donation 5 Other (S) 21. Sending of Funeral Service	icensee to	how	22. THO	Name and ORNTON	URCH Address of FUNE	Facility ERAL H	OME, P.A						
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attend within 24 hours effer death To the Funeral Director: / completely filled in by the f

State Registrar 29b. Signature and title of certifier - IM 29c. License number

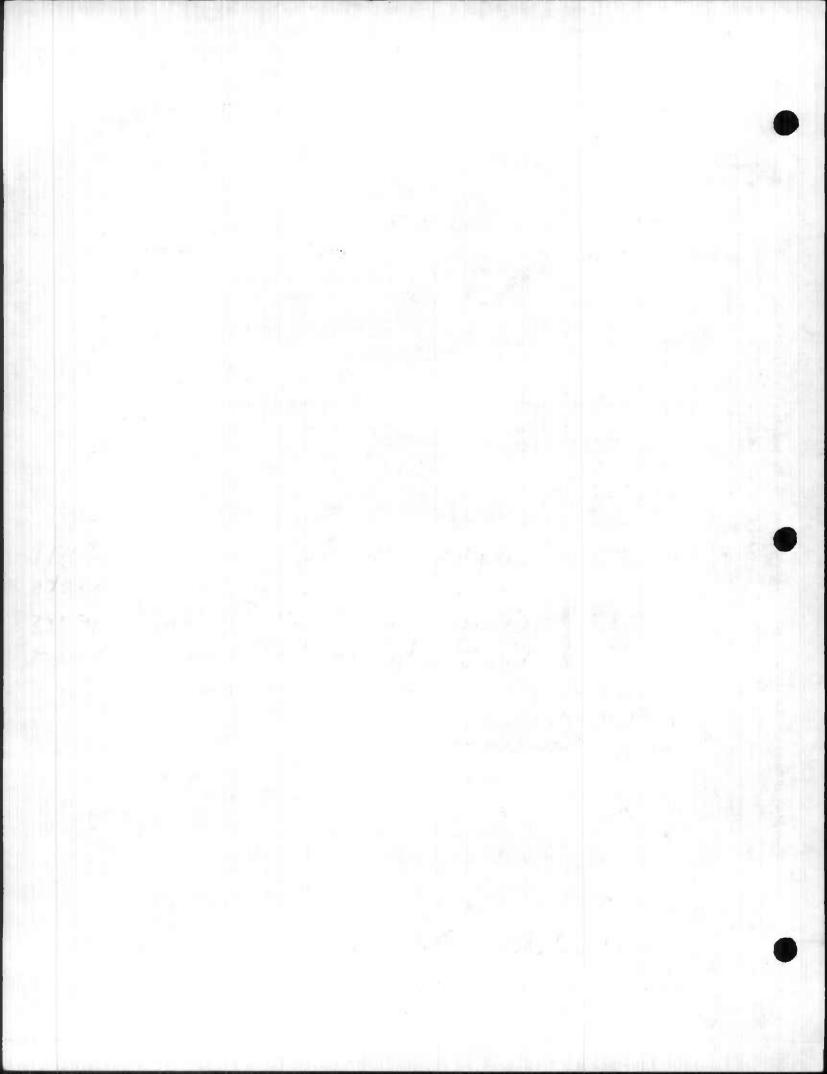
D- 46046

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

Amir A. Mirza Alikhani, M.D. 118 LaGrange Ave, P.O. Box 1890, LaPlata, Maryland 20646

31. Date filed (Month, Day, Year)
APR 0 3 2000

32. Registrar's Signature

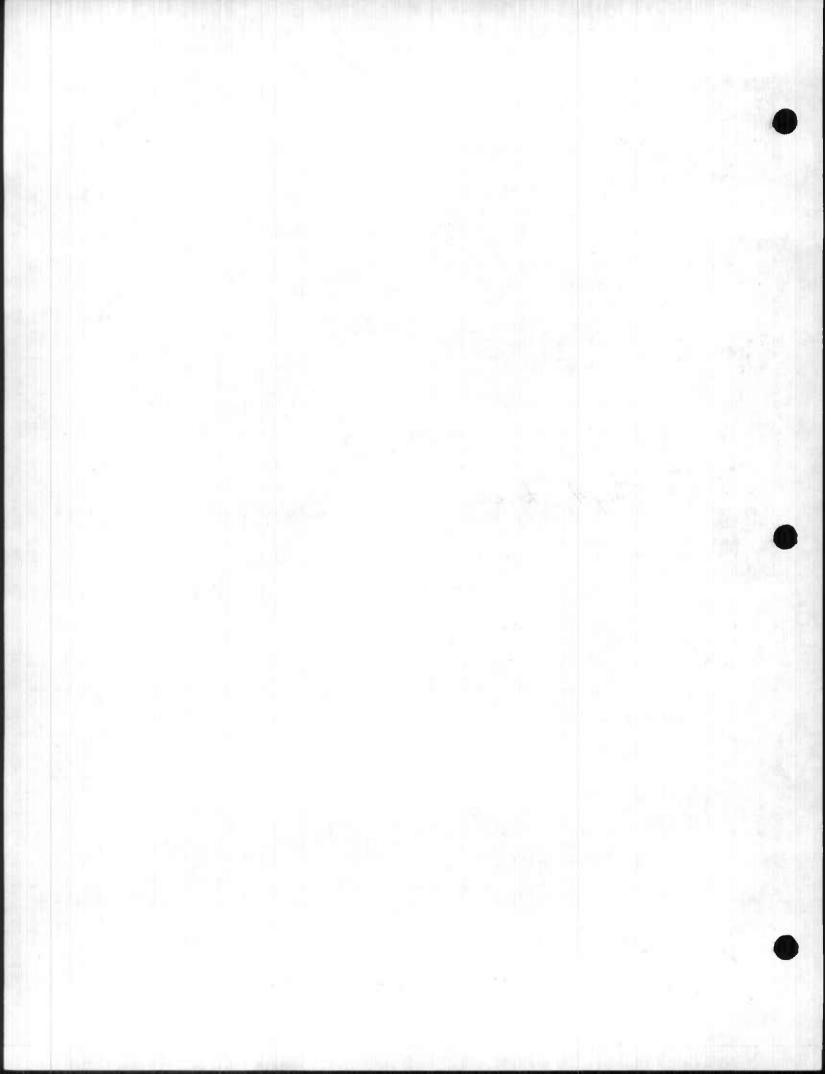


#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Catherine Versace    March 28, 2000   6:40 a				,	Certifica	ate of	Death		Reg. No.	0 1	1838		
Catherine   Versace   March 28, 2000   6:40   8	Physician	1. Decedent's Neme (First, Middle,	Last)								3. Time of Deat		
The Period Prince of County of Death Prince George's    Social Security Number of Indian Engineering County of Death   Social Security Number	•	Catherine V	ersace					March 2	28, 2000		6:40 ar		
S. Solid Spoonly Number   S. South Spoonly Number   See   Se		4a Facility Name (If not institution,	give street and number	r)			4b. City, Town, or Li	ocation of Death	4c. County of	of Death			
Source   S		7020 Riggs Road					Hyattsvil	le	Prince	Geor	ge's		
Symbol   S	Funeral			ige (In yrs. lest b				8. Date of Birt	h v Year)	9. Birthplac	e (State or Fore		
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Anthony F. Barilla / Nephew 7020 Riggs Road, Hyattsville, MD 20783  20a. Method of Disposition 12 Chemistry Specific Manage of Disposition (Name of Disposit		Antonino Ottone					Giovanna	Marcia	no				
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Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.   23b. Did tobacco use contribute to the cause of death of dea	Depart Import any Inj	Francis J. Collins Funeral Home, Inc											
Michigan	111111111111111111111111111111111111111	I RACY H.	Triver		500 U	niver	sity Blvd	l., W, S	ilverSpr				
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25. Was case referred to medical examiner?  1   Yes 2   Xes   No    27. Manner of Death 1   Xes   Xes   No    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   28	2 sh	Hypothyroldism								of de	otetion of cause ath?		
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D17843  March 28, 2000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Vivek C. Vaid, MD 3311 Toledo Terrace, Hyattsville, MD 20782	tor. p	25. Was case referred to medical					26. Place of Deat	h (Check only o	ne)				
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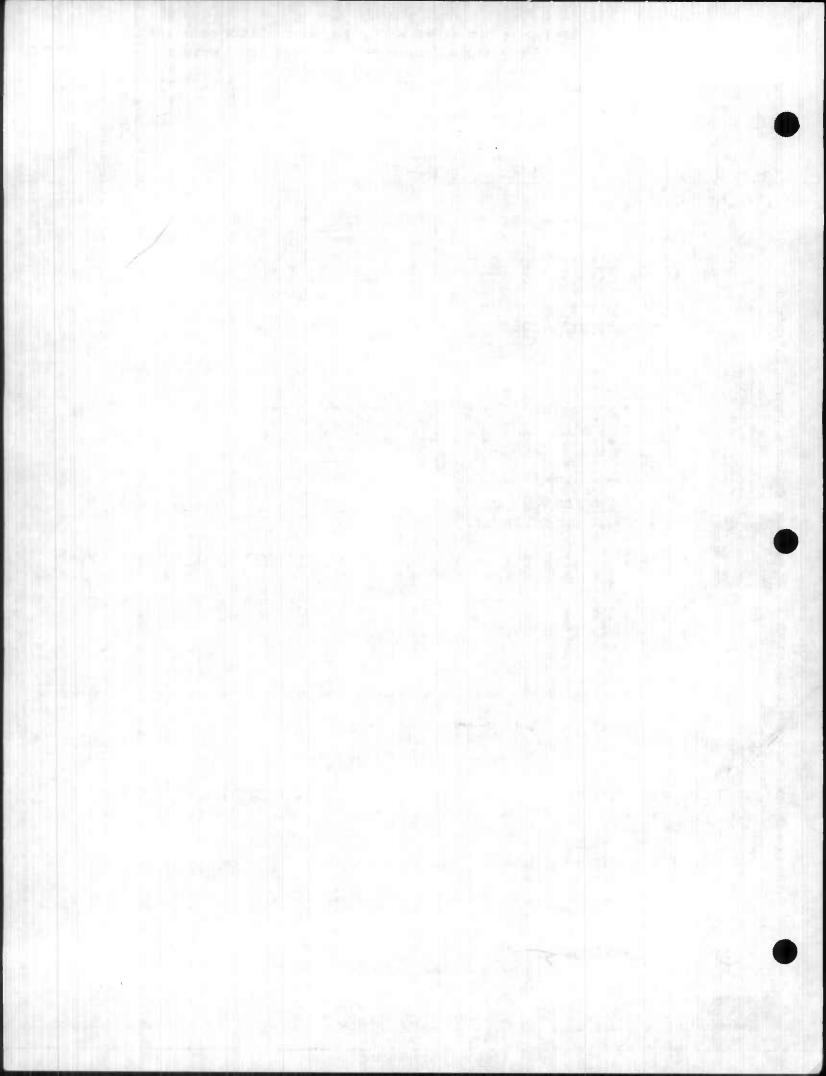
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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					Ce	nilica	te or	Death			Reg. No.			
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/Medical	JEANNE	L. VIQU	JEIRA								21, 2	000	0420	AM
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	SHA	DY GROVE	ADVE	NTIST	HOSPI					LLE	MC	NTGO	MERY	
Funeral	5. Social Security		Sex	7. Age (In yrs	s. last birthday)	If Unde Months	or 1 Year Days	If Under	24 Hrs. Min.	8. Date of B	inth ey, Year)	9. Birt	hplace (State ountry) hington	or Foreig
Director	577-34-0	1439	1□M 2XF		71 Yrs.					July 1	2, 192	8 Was	hington	, DC
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iner must iner must Funeral	11. Marital Status		12. Was Dec Armed F	cedent Ever in orces?	U,S. 13.	Was Dece	edent of h	li <i>s</i> panic Orig	gin? (Sp	ecify Yea or N Rican, etc.)	0- 14.	Raca - Ame Black, Whit	erican Indian, e. etc.	
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10 E 0	17. Father's Name	e (First, Middle, Last	)					18. Mothe	r's Name	e (First, Middle	e, Maiden Su	meme)		
To B		ter Sila	Post	on					Ida	Bell	Thoma	S		
-		Neme/Reletionship	Type, Print)		19b. Maili	ing Addres	s (Street	and Numbe	or or Run	al Route Num	ber, City or To	own, Stata,	Zip Code)	
10.10	John Vie	queira	(	Son)	125	17 De	oude	s Roa	d	Boy	ds, MD	2084	1	
# ff.	20a. Method of Di				Place of Dispo	osition (Ne	other pla	ce)		Date	20c. Locat	ion - City or	Town, State	
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and a		uneral Service Lice	**								10210	01102		
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and blue de by											s en eutopsy	24b.	Were eutopsy	tindings
should should been si										per	formed?		available prior completion of deeth?	
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or: A	2 Accident	investigetion				М	1	Yes 2	No					
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ous runeral brector; Arier in completely filled in by the funeral Medical Certification; 1	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and man and manner stated.											s)		
To the Funeral Director: A completely filled in by the fi	29b. Signature and title of certifier							se number			29d. Date s	igned (Mon	th, Dey, Year)	
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(2)	2	rain	5								1.144			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TRA BETYER M.D. 809 VENS MIII POAD, ROCKVIK, MAYING 30851												
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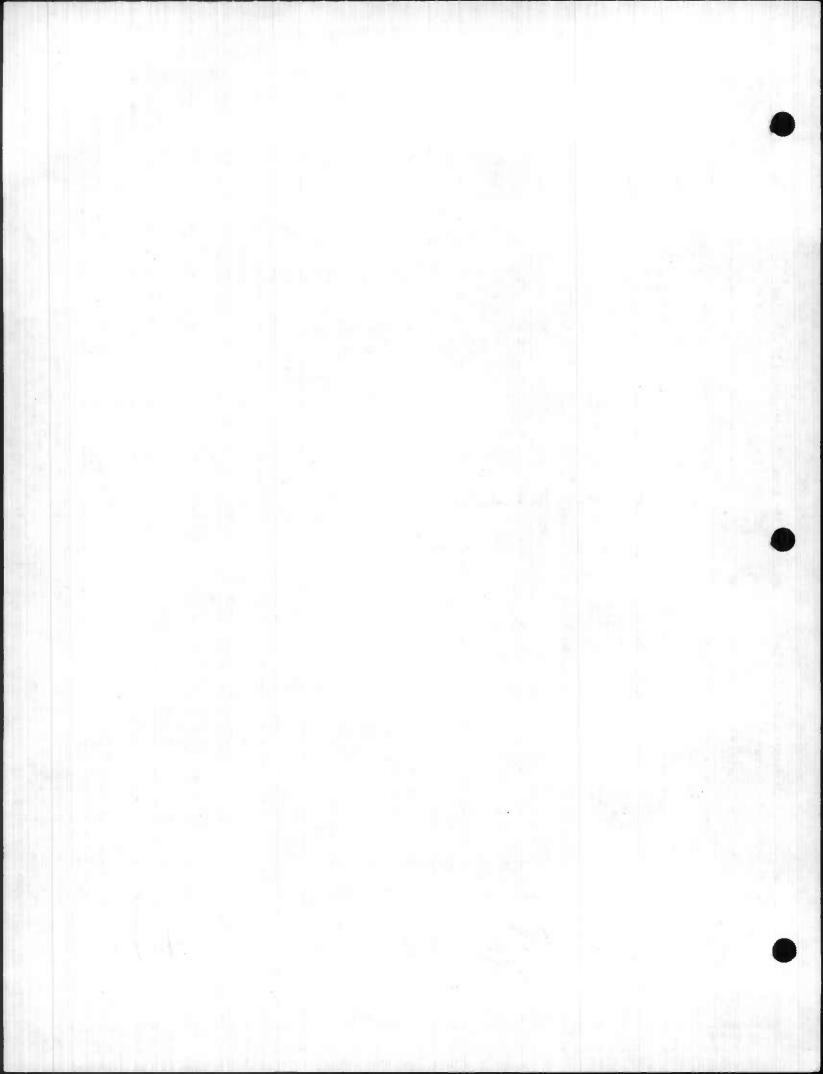
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** WEISS ROBERT В. 21, 2000 8:05AM MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys XM 2DF Yrs. Director ILLINOIS 310 18 2781 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahos with the Maryle must be notified at MARYLAND MONTGOMERY ROCKVILLE 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or 6111 MONTROSE ROAD 20852 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1/CVes 2 □ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filled within 72 hours after nant of Health and Mental Hygiene. unt: if Item 27 te marked other than "natural", or Ite 1 Never Married Married 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygians. Elementery/Secondery (0-12) College (1-4or 5+) REAL ESTATE SELF EMPLOYED Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ERVIN WEISS HELEN ATLAS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 15 CUMMINGS CIRCLE WEST ORANGE, NEW JERSEY 07052 ADAM WEISS/SON other Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Pennoval from State ö Department of important: If any injury or otics. 4 □ Donation 5 □ Other (Specify) KING DAVID MEM GDNS. 3/24/00 FALLS CHURCH, VIRGINIA 21. Signature of Funerel Servin 22. Name end Address of Facility NATIONAL FUNERAL HOME LEE HIGHWAY FALLS CHURCH, VIRGINIA 22042 7482 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heaf failure. List only one cause on each line. Approximeta Interval Between Onset and Deeth **Physician** /Medical Immediate ( ause (Final disease or comment resulting in death) 1 DAY SEPTIC SHOCK Examiner Due to (or as a consequence of): Examiner 2 DAYS b. PERITONITIS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as e consequence of): Box 68760, 3 DAYS physician SMALL BOWEL PERFORATION Physician/Medical the Due to (or es e consequence of) 88 for use 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 □ Yes AND à of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy parformed? certificate hes 1 Yes ZANo 1 Yes 2 No al or Attending Physician: The atterdeath.

In Director: After this certificated in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Y Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Division 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital To the Hospital within 24 hours a To the Funeral E 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner steted. Medical 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed Month, Day, Year) 29b. Signature end title of certified e 00 3 5 voluse of death (Item 23a) (Type, Print) 30. Name and address of person who complete AVENUE KENSINGTON, MARYLAND VICTOR STEIGER, M.D. 10810 CONNECTICUT 20895 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State MAR 2 7 2000 souls

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Ealise Marsh Weisz March 26, 2000 2:31 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 10, 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F 76 Virginia Yrs. 230-14-5402 Director Usual Residence of Decedent ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Peges 1 and 2 should be filed within 72 hours after death with the Maryler Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show among yor other traumatic event, the Medical Examiner must be notified an once. 1KIYes 2∏No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Lawngate Court 20854 United States Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Giva Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Salesperson Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Lawrence Marsh Ida B. Booth 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4507 Butler Drive, Fairfax, Virginia 22030 Franklin L. Combs/Son 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition March 30 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete National Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2000 Falls Church, Virginia 21. Signature-of Funaral Sarvice Licensee R22, Nome and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Massive Intra Cerebral Bleed disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Cardio-pulmonary Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): signed by the at d be deteched for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24b. Were autopsy findings eveilable prior to completion of causa of death? 24a. Wes an autopsy performed? page 2 should Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Attending 1 X Natural deeth. 1 Yes 2 No 2 Accident after deet! Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 hours a Hospital 24 hours edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year) of certifier D29224 March 26, 2000

State Registrar

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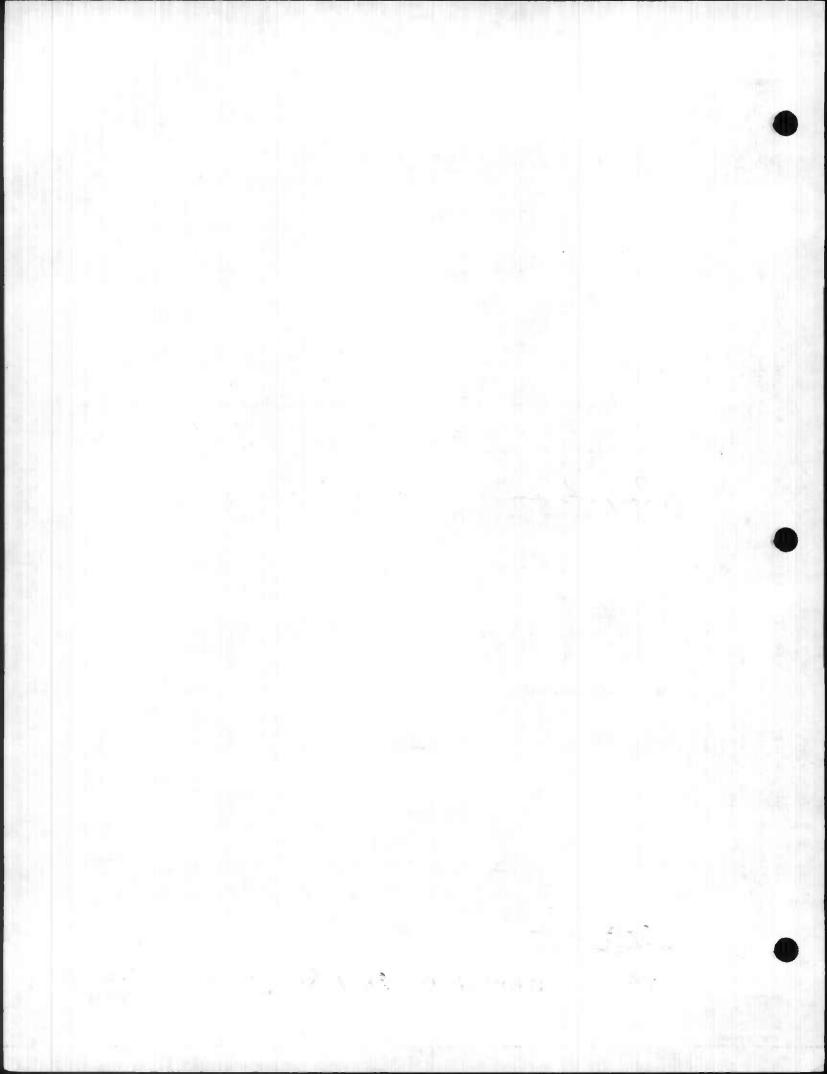
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SAI ED JAMSHIDI 9801 Georg t'a 32. Registrer's Signetura

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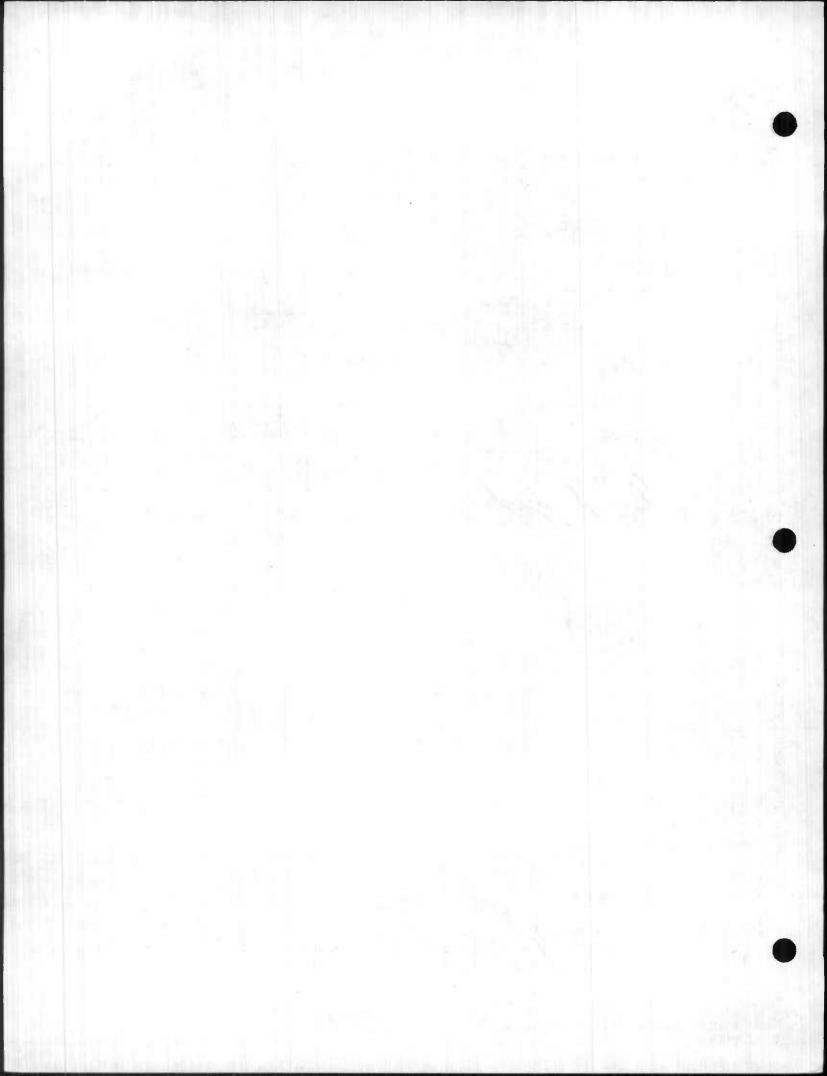
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State of Maryland / Department of Health and Mental Hygiene

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Physician	1. Decedent's Nam	ne (First, Middle, L	ast)						2. Dete of Do Month	Dey	Year	3. Time of Death
/Medical	Bobby L.						-		March			5:50 pm
Examiner	4a Facility Neme (	If not institution, g	ive street and numb	er)				4b. City, Town, o	r Location of Deat	th 4c. Count	ty of Death	
			heel Driv	e		27		Germanto	own	Mont	gomer	
uneral	5. Social Security f	Number 6.		Age (In yrs. I		If Under 1	Year Days	If Under 24 Hr Hours Min		rth ay, Year)	9. Birth	place (State or Foreigntry)
rector	408-66-27	46	1⊠M 2□F	57	Yrs.					5,1942		tucky
	Usuel Residence of	of Decedent	,	10.00								
terns 23a or 23a-f show ner must be notified at funeral Director	10a. Stata	10b. County		10c. City	, Town or Lo	cation					1	10d. Inside City Limit
of the	Maryland	Montgom	ery	Germ	antown	1						1 ☐ Yes 2X N
be notified Directo	10e. Street and Nu	mber				10f. Zip (	Code			10g. Citizen of	What Cour	ntry?
2 2	13531 Spi	nning Wh	eel Drive			208	7/			USA		
iner must Funeral	11. Merital Status	MILITE WIL	12. Wes Decede	ent Ever in U.	S. 13. V			lispanic Origin? (	(Specify Yes or Norto Rican, etc.)		ce - Americ	
Fu	1 Never Men	ried 2 Married	Armed Force						erto Hican, etc.)		eck, White,	
à	3 ☐ Widowed	4 Divorced	If Yes, Give Year or Date	98:	1	1□Yes 2	□¥No	Specify:		Speci	by: Whi	.te
	-	15. Decedent's I	Education		16a. Deced	ient's Usual	Occur	pation		16b. Kind of I	Business/In	dustry
Completed	-	cify only highest g	rade completed)		(Give	kind of work	done	during most of w	orking			,
Ë	Elementary/Sec	ondary (0-12)	College (1-4	or 5+)						Floor	ond or	
	12 17. Fether's Name	/Figure Adichello I as	-d1		Frect	rontc	Enj	gineer	ame (First, Middle	Electr		
Be			• ()							, maideir Suite	me)	
2	Charles	Welch						Ethel W	ampler			
	19e. Informent's N	lame/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street	and Number or I	Rural Route Numb	ber, City or Town	n, State, Zip	Code)
	Kathleen	K. Welch	1 / Wife		13531	Spin	ning	g Wheel	Drive, C	Germanto	wn, M	id 20874
2	20a. Method of Dis	position			ace of Dispos	sition (Nem	e of	cel	Dete	20c. Location	- City or To	own, Stete
		☐ Cremetion 3 5 ☐ Other (Spec	☐Removel from Ste	Ate l				emetery	3/28/00	Silver	Spri	ng, MD
	21. Signature of F		**					ss of Fecility				
8	6			1					s Funera	1 Home,	Inc.	
	42	us	scere	0							ring,	MD 2090
	23a. Pert1 Enter	the disease, or cal art feilure. List onl	nplications thet cau y one cause on eec	sed the death h line.	. Do not ente	er the mode	of dyir	ng, such es cardi	ec or respiratory	arrest,		Approximate Interval Between
an												Onset end Deeth
ıl — r	Immediete Cause disease or condition	(Finel	Esoph	agel Ca	ancer							1 year
	resulting in death)		а		as a conseq	uence of):					1	
	10000			•								
Examiner	Convention to the		b	Due to (or	es a conseq	neuce of).						
EXS	Sequentially list or if any, leading to ir cause. Enter Und	nmediate		220 10 (0.	40 a 0011004	301100 017.					1	
Cal	Cause (Disease or that initiated event	ranjury	C	Due to for		unnan all						
Medical	resulting in death)	Last		Due to (or	es a consequ	uerice or).						
			d									
Physician												
ys	Part II. Other signi	licant conditions	contributing to deat	h but not resu	ilting in the ur	nderlying ca	use gn	en in Pert I.				o the cause of dear
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by											T	
Completed									24a. We	s en autopsy ormed?	81	ere autopsy finding reilable prior to
ple											of	ompletion of cause death?
E									1 🗆	Yas 2 No	1	Yes 20XNo
	25. Wes case refe	rred to medical						26 Place of D	eeth (Check only			
o Be	axaminer?		Hospitel:	-tit 001	FD10-1-1-1-		Ott	oer.			at (C	24.4
To To	27. Manner of Dear		1 Inp		ER/Outpatien 28b. Time of		4	4 LI Nursing	Home 5 Tares	how injury occi		ry)
Certification:	1 Neturel	5 Pending	28a. Date of I (Month,	Day Year)	Injury		kc. Injui		200. 00001100	now injury occi	11100	
cat	2 Accident 3 Suicide	investigati	he			M		Yes 2 □ No				
E	4 Homicide	determine	200. Place of	Injury - At ho , etc. (Specify	me, farm, stre ')	eet, fectory,	office			(Street and Nun iwn, Stata)	iber or Run	al Route Number,
3												
edical	29a, Certifier (Check only		hysician/ To the be									
	one)	Z   MY GICE! EX	miner: On the basis	Theiria	TOTAL BETTER OF THE	esugetion,	ar my c	динон, авен ос	COLLEG AL USA HUUG	, Jare end piace	, and due t	o are cause(s)
Σ	29b. Signeture and	title of certifler	NI	-		29c.	Licens	se number	THE	29d. Date sign	ed (Month,	Day, Year)
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			Completed cause							41.00		
	Ken Mill			nce Ph		rive	, 0	lney , M	D 20832	2		
tate	31. Date filed (Mor	III, Day, Year)	1000	istrar's Signat	lure	do						
strar		MAK & T	2000	yeur	Ø.	000	2K	2				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year Physician Patricia Tarise Welsh 20 2000 1:50p.m. March /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 213-32-9550 Director 64 October 12 1935 MD Usual Residence of Deceden 10a Stata permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Heelih and Mental Hyglena. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow any highry or other traumatic event, the Medical Exercises must be nowned at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Road 21286 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian Bleck, Whita, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Plumbing Supply 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Eadgar Wellschlager Elsie Potts 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33460 38th Street S.W. Federal Way, WA Bridget Welsh - daughter 98023 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2X Cramation 3 ☐ Removal from State Chesapeake Crematory, Inc 3-31-00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 21. Signature of Funeral Service Licenses 8717 Green Pastures Drive, Towson, MD 21286 Pert: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in death) Examine Dua to (or as a consequence of) Examiner physician and the burief-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medicai Dua to (or as a consequence of) 980 20 D.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Ď 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed page 2 1 Yas 2 No 1 Yas 2 No certificata or Attending Physicien: director. 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 0 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death
12 Natural
2 Accident 28e. Data of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending n 24 hours after deeth.

Ne Funeral Director: After pletsiy filled in by the fun 1 ☐ Yas 2 ☐ No investigation 6 Could not be detarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled in The Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. edical 29a. Certifier (Check only 29b. Signature and 29c. License number 29d. Data signed (Month, Day, Year) 00 5364 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) GANES 6701 N. Charles St Baltimore, MD 21204

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

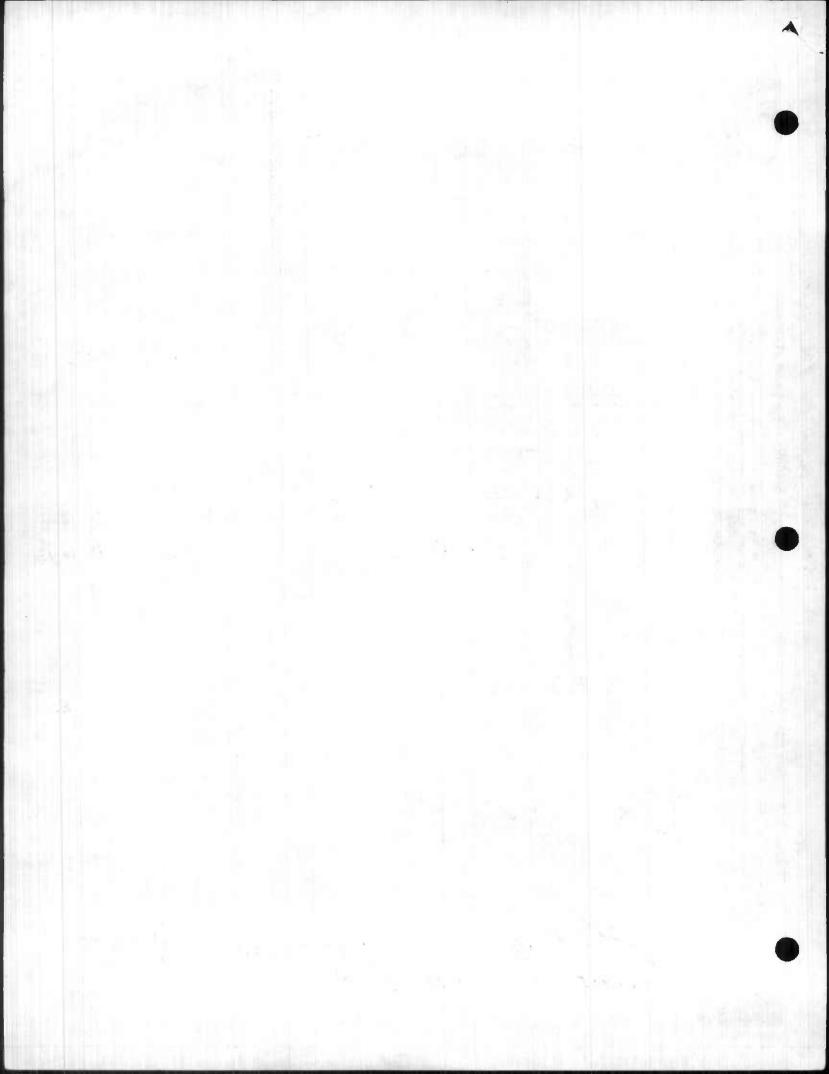
MAR 28 2000

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Ei

32. Registrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 864 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Ruth Ellen Wands 27, 2000 12:30 pm March /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carroll If Under 24 Hrs. H Linder 1 Vear Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 219-20-8660 74 Director May 11,1925 Pennsylvania Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23s or 28s-f show traumatic avent, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Millers Maryland 10a Street and Number 10g. Citizen of What Country? 10f. Zio Code permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is merited other than "natural", or items 23s or it any injury or other traumstic avent, the Madical Experiment 23s or 2006. 20991 Gunpowder Road 21102 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Bleck, While, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify White þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Charles Balliet Stella Mae Stair 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alauna Boykin, daughter 20991 Gunpowder Rd, Millers, MD 21102 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Carroll Cremations 3/28 Hampstead, MD 22. Name end Address of Fecility 21. Signeture of Fyneral Service Licensee M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical nemmone Examiner Due to (or as a consequence of) by Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) and Be Completed

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; s edical Certification: To

	d							
Part II. Other aignificant conditions or	entributing to death but not re-	sulting in the underlyin	g caus	e given in Pert I.	23		KNo	stributa to the cause of death?
	kulla				24	e. Was an eutops performed?	у	24b. Were autopsy findings available prior to completion of cause of death?
						1 ☐ Yes 2 🖾	No	1 Yes 2 No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA	Other: 4 Nursing			Othe	er (Specify)
27. Manner of Death  1 Neturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury et Work? 1 Yes 2 No	28d. De	escribe how injury	occurr	ed
3 Suicide 6 Could not be determined	28e. Plece of Injury - Ath building, etc. (Speci		tory, of	ffice	28f, Loc Cit	cation (Street end y or Town, Stete)	Numbe	er or Rural Route Number,
	rsician: To the best of my kno							

29c. License number

State Registrar 29b. Signeture and little of certifier

odle

31. Date tiled (Month, Day, Year) 32. Registrar's Signature MAR 2 9 2000

pleted cause of death (Item 23a) (Type, Print)

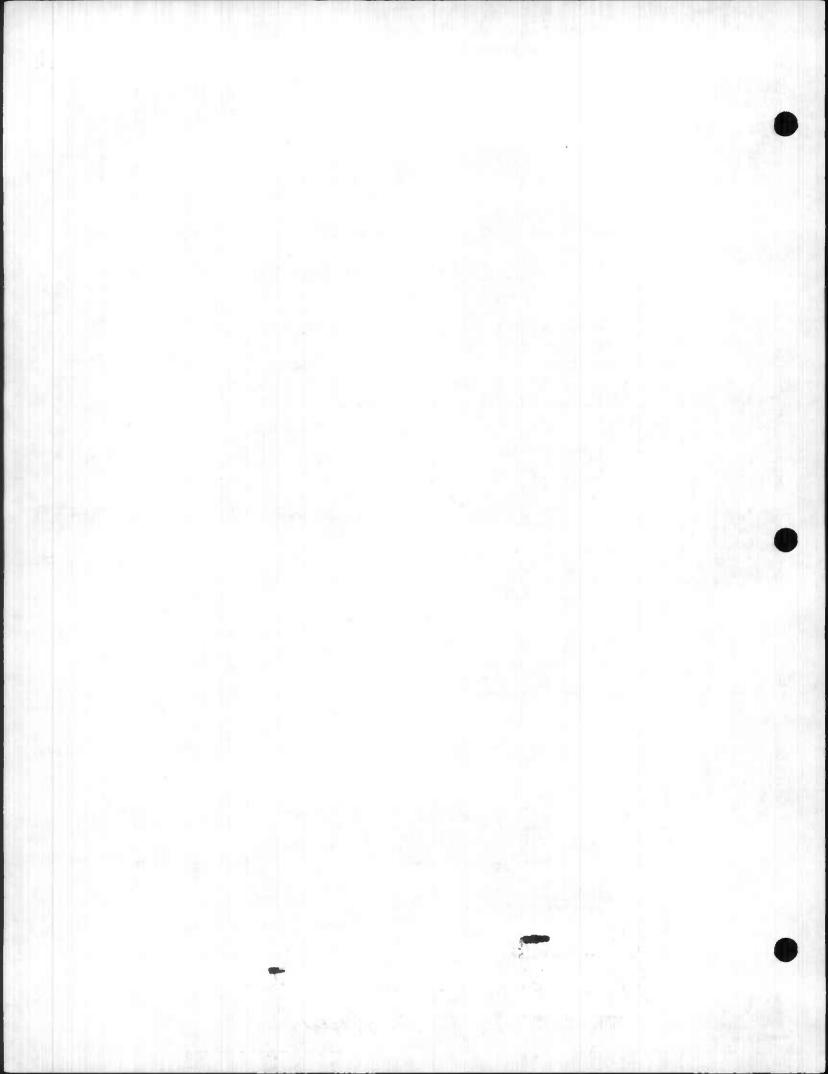
7,000

29d. Date signed (Month, Day, Year)

John W. Middleton

**DHMH 16 Rav 6/95** 

W Btmms ter



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Joan H. Yenca March 24, 2000 10:46 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months 72 Director 180-22-8113 Nov 9, 1927 Ohio Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director 28a-f Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 230 20851 USA 5700 Vandergrift Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: or Itsems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rained Health and Medical Hydisens. Institutely, or less the transfeed other than "natural; or less ity or other traumatic event, the Medical Examinative or other traumatic event, the Medical Examinative 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 88 Joanna Curran Andrew Thomas Butkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 N. Fairfax Dr., Villa 1714, Arlington, VA2220 Andrew Yenca/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete ant: If I Gate of Heaven Cemetery 3/28/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mpor iny in Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, SilverSpring, MD 20901 Britt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Interval Between Onset and Death **Physician** Ovarign Cancer Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai \$ Due to (or es a consequence of): for use as signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificate 1 Yes 20 No Division of Vitai or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 发 EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

**DHMH 16 Rev 6/95** 

State

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mendhiratta

2000

31. Date filed (Month, Day, Year)

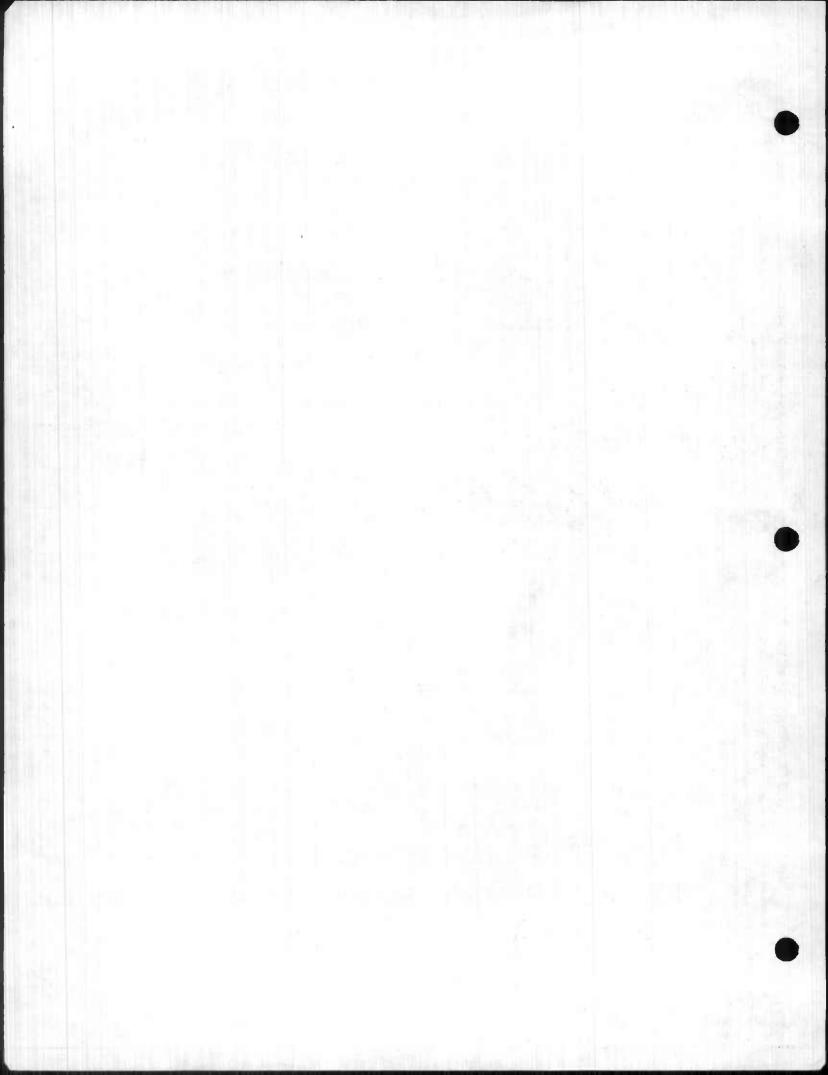
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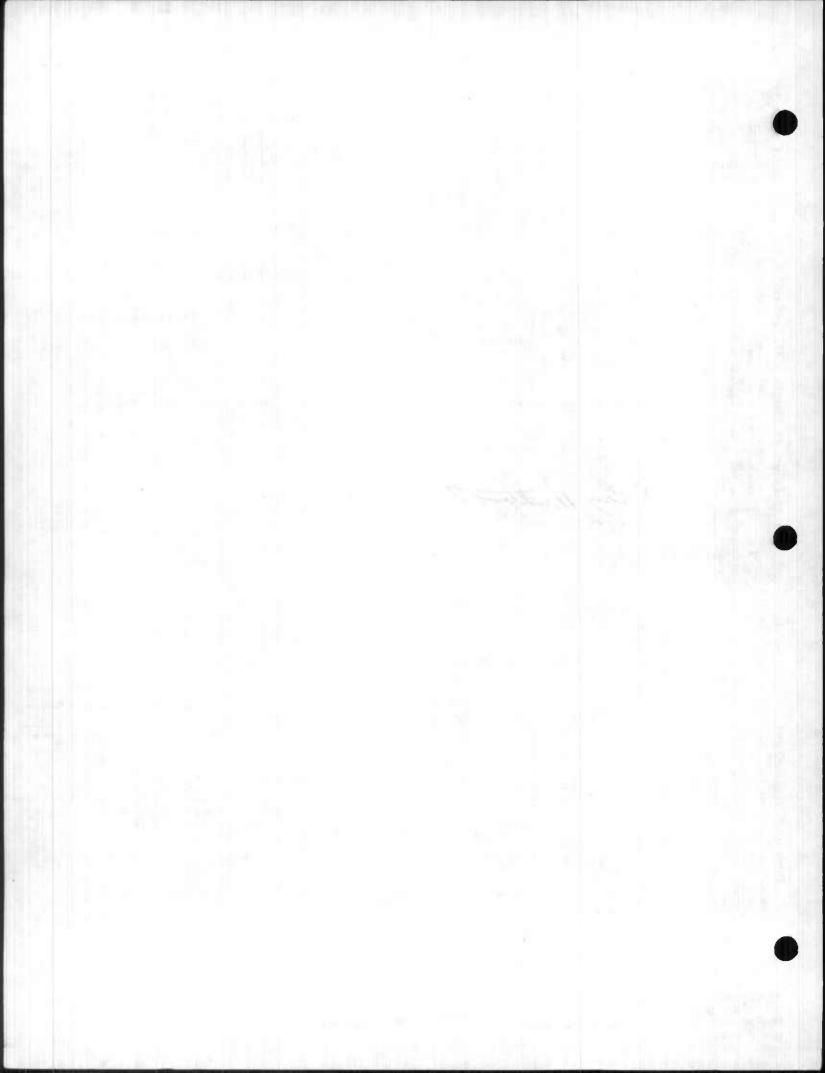
2401 Research Burn Suite 340 Rockville MM

March 25, 2000



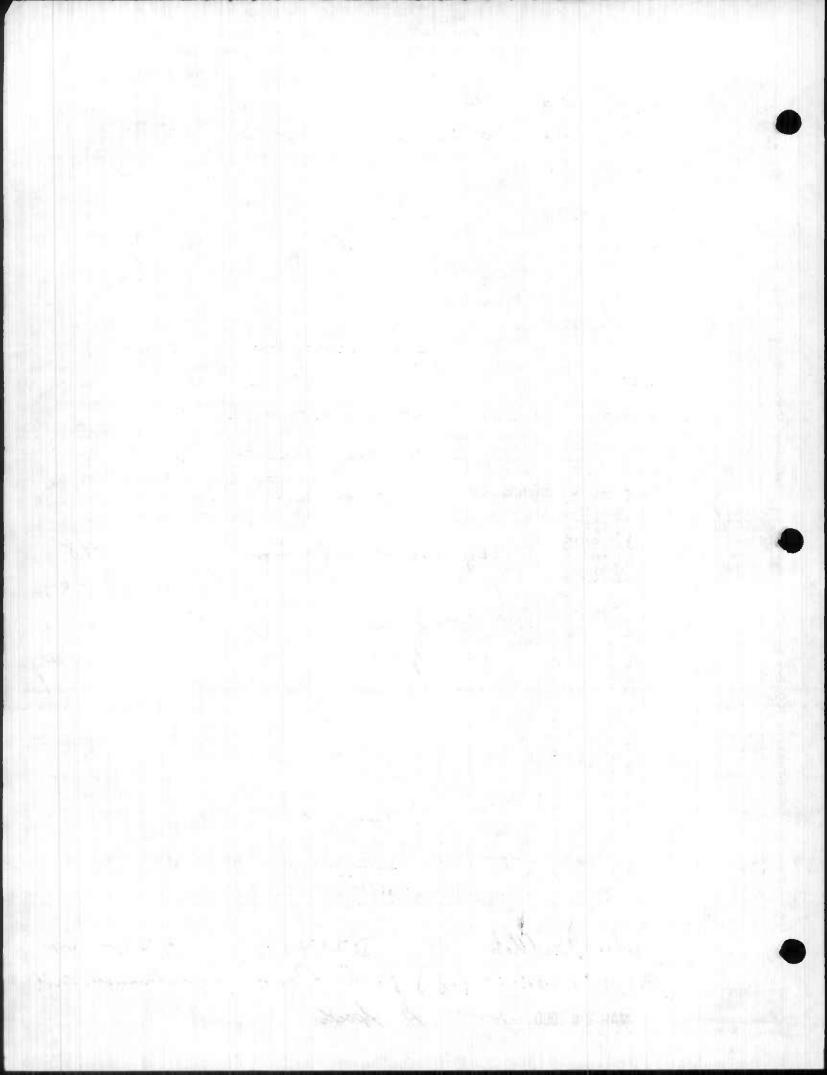
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	etate of that years a	Certificate of Death	Reg. No.	11846		
D1	Decedent's Neme (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death		
Physician /Medica	DENINE IN ELIWARD	ZENDGRAFT	MARCH 26, 2000			
Examine	to Footbar his on a 100 and locally size of a standard and a section	4b. City, Town, or Li	ocation of Death 4c. County of Dea	ath		
	CARROLL COUNTY GENERAL HOSPI					
Funeral Director	5. Social Security Number  216-22-7961  Usual Residence of Decedent  6. Sex  1 M 2 F  7. Age (In yrs. last bir	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		rthplace (State or Foreign country) RYLAND		
dand dand	10a. Stete 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits		
Many Price of the	MD. CARROLL WEST	MINSTER		1 No Yes 2 No		
a or 28a-f el		10f. Zip Code . 21157	10g. Citizen of What C	What Country?		
21215-0020  d within 72 hours after death with the Maryland glene. It then "natural", or flems 23s or 28s-f show the Medical Essenting must be notified at commission by Emperal Directors.	3℃ Widowed 4 Divorced Hear or Detes: WW II	13. Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)  14. Race - Am Bleck, Wh Specify: WH	ite, etc.		
21215-002  ed within 72 hours  ygiene,  ygiene,  rgar than "natural",  ft, the Madell Ele	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business	s/Industry		
within the	Elementary/Secondery (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)  TRUCK DRIVER		MA MITON		
			TRANSPOR	CTATION		
land id be file ental Hyrked other ic event,			e (First, Middle, Maiden Surname)	7 7 14		
laryian 2 should be and Mental and Mental and Mental and Mental			ETHEL BUCKINGH			
		. Meiling Address (Street end Number or Flur 308 WOODLAND DR., 1	the strain entrance of the strain of			
		f Disposition (Name of ry, cremetory or other place)	Date 20c. Location - City o			
Page nento	4 Donetion 5 Other (Specify) WESTM	ry, cremetory or other place) INSTER CEMETERY3				
Balt pemit. Departu importa any inje	21. Signeture of Funerel Service Licentus	22. Name and Address of Fecility FI	LETCHER FUNERAL , WESTMINSTER,			
Physician /Medical Examiner		YSEMA consequence of):		Interval Between Onset and Death		
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Box Bath cert for use						
the d	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Pert I.	23b. Did tobacco use contribut	ie to the cause of death?  Probably 4 Unknown		
Ped			24a. Was an eutopsy performed?	. Were autopsy findings available prior to completion of cause		
VITAI REC sterificate has b director, page 2 si			1□ Yes 2000	of death?		
<u>-</u> F ਵੱਕੇ ਨੂੰ	25. Was case referred to medical	as Bloom of David		TLI TAS ZLINO		
Of VICE Physician: this certific tral director,	axaminer?  1 Yes 2 No Hospitel: 1 Inpatient 2 NER/Ou	Others	th <i>(Check only one)</i> oma 5 ☐ Residence 6 ☐ Other <i>(Sp</i>	acity)		
	27. Mapner of Deeth 28e. Date of Injury 28b. 1	Time of njury M 1 Yes 2 No	28d. Describe how injury occurred	ecity)		
DIVISION C below Attending P is after death. In Director: After the din by the funara Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Pleca of Injury - At home, fa building, etc. (Specify)					
Hospi 4 hour Funer tely fill	29a. Certifier (Check only Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examinetion an end menner steted.	, deeth occurred et the time, date end piece, d/or investigation, in my opinion, deeth occur	and due to the cause(s) and manner a red at the time, date and place, and du	ns stated. ne to the cause(s)		
To the i within 2 To the comple	29b. Signature and title of capitier	29c. License number 29 246	29d. Date signed (Mor			
	30. Name and accress of person who completed cause of death (Item 23a) in the second s	(Type, Print) for HIS. Wa	Immster ou	21157		
State Registrar	31. Defe filed (Month, Dey, Year)  32. Registrar's Signature	4 hours				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic	an	Dacedent's Name (First, Market Leonard)	Middle, Las Frar		Zito				2. Date of Dea Month	Day	3. Time	
/Medi Examii	cai	4a. Facility Nama (If not instituted Name (If not inst	itution, give	straet and nu	ım <i>bar)</i>	ogont C	ontor	4b. City, Town, or L Westmins		26 200 4c. County of Carro	of Death	)pm
Funeral Director		5. Social Security Number 216–01–8559	6. Se			. last birthday) Yrs.	if Undar 1 Yaar Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Day	, Yeer)	9. Birthplace (Stat	a or Fc
		Usual Residence of Deceder	nt						Dec 13	1907	Md	
Mow W		10a. State 10b. Co			10c. C	ity, Town or Lo			4		10d. Inside	City L
i i	cto	Md Ca	rroll			Woodb	ine					es 2
ath with the 23s or 2 wat be no		10e. Street and Number 5631 Manor	Drive				10f. Zip Code 21797			10g. Citizen of What Country? USA		
olf, o	d by Funeral Director	11. Maritai Status  1 Never Married 2 3 Widowad 4 Divo		Armad F	2X) No		Vas Decedent of I f Yes, specify Cub ☐ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puarto Specify:	pecify Yas or No- Rican, etc.)		ace - Americen Indian, lack, White, etc. hify: white	
"naturel",	etec	15. Dece (Spacify only h	edent's Ed	ucation le com <i>pleted)</i>		16a. Deced	ent's Usual Occup kind of work done	oation during most of work	ina	16b. Kind of Bus	siness/Industry	
than Tra Me	Completed	Elementery/Secondary (0-	12)	College (	1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) tire maintenance worker			automot	ive	
ntal Hygiene. d other than event, tre	ပိ	17. Father's Name (First, Mic	idle Last)			CITC	mainten.	18. Mother's Nam				
d o	To Be	Joseph Zito						Marie Mo			"	
alth end Mental Hygi 27 Is marked other r traumatic event, I	T	19e. Informant's Name/Reia Betty Lou Fis		ype, Print) laughte	er)			and Number or Aur n, Finksb			State, Zip Code)	
nent of Health nt: If item 27 in iry or other tra		20a. Method of Disposition  1 □ Burial 2 □ Cremat  4 □ Donation 5 □ Othe			Stata Lal	Place of Disposementery, crem	sition (Name of natory or other pla Memoria	l Park 3	Date 30-2000		City or Town, State	
Department Important: I any injury o		21. Signature of Funeral Ser			ent		Name and Addra	ass of Facility Ha 195 Sykes	_		me & Char	æl
nysician Medicai xaminer		23a. Part1. Entar the diseas shock, or heart failure. Immediate Cause (Final diseasa or condition resulting in death)	List only o					firetin			Intervel B Onset an	d Daa
physician and s the buriel-trensit	Examiner	Sequentially list conditions, if any leading to immediate	•	b	Pue to (	or as a consequ	uence of):				2	00
sician	E E	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events	2	c/	en	rener	ic				6	9
0 0	Physician/Medical	Dua to (or as a consequence of):  One of the initiated events  Dua to (or as a consequence of):									50	le
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e ettendir d for use	Physic	Part II Other eignificant con	ditions co	atributing to d	nath but not re-	ulting In the un	dadulas acusa sh	ren la Part I	22h Dida			
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s certificate has been signed by th director, page 2 should be detache	Medical Certification: To Be Completed by	25. Was cese refarred to med axaminar?  1  Yes 2  No  27. Manner of Death  1  Netural 5  Pe 2  Accident inv 3  Suicide 6  Co 4  Homicide  29e. Certifier (Check only one)  29b. Signature and title of cert	nding estigation uld not be termined	28a. Date (Monical 28e. Place building and manical 28e. Place building and place buildi	inpatient 2 of Injury  of Injury - At h ng, etc. (Speci best of my kno asis of examine her statad.	28b. Time of Injury oma, farm, stre	3 DOA Oth  28c. Injur  Wor 1 D  et, factory, office  occurred et the tir estigation, in my of the setting of th	26. Place of Deather: 4 Nursing Ho y at k? Yes 2 No	24a. Was a perfor  1 Y  h (Check only or one 5 Resid 28d. Describe h 28f. Location (S City or Towned at the time, d 2	in autopsy med?  es 2 No  es 2 No  es 6 Other  ow injury occurre  tireet and Number  n, Stete)  ause(s) and manuate and place, an	24b. Were autops available pric completion of death?  1 Yes 2  (Specify)  d  r or Rural Route Numer as stated.  Indidue to the cause	Un U



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Year AULL 6:30 PM APRIL 9, 2000 4c. County of Death ANNA 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death BAYVIEW MEDILAL CENTER BALTIMORE Johns HOPKINS N/A If Under 1 Yeer If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Deys Months Hours 1□M 2XF 88 Sept. 26, 1911 216-01-1738 Maryland Usuel Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2904 E. Pratt St. U. S. A. 21224 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Maritel Status Black, Whita, atc. 1 ☐ Yas 2 🔯 No If Yes, Giva 1 Never Merriad 2 Married 1 Yes 2 No Specify: Specify: White 3 Nidowed 4 □ Divorced Yaar or Datas: 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade Collega (1-4or 5+) Saleslady Hat Company 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Thomas C. Arthur Margaret Herr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Richard J. Aull Jr. 5 Quelet Court, Baltimore, Maryland 21236 (Son) 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removal from Steta 4 ☐ Donation 5 ☐ Othar (Specify) Most Holy Redeemer 4/12/00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schumuner Funeral Home Inc. Brehms Lane, Baltimore, Maryland 21213 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Ceuse (Final diseasa or condition rasulting in deeth) KESPIRATORY RREST MINUTES Due to (or as a consequance of) L WEEKS LMONARY Sequentially list conditions, if any, laading to immadiate ceusa. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Lest Dua to (or as a consequence of) WEEK ROSEPSIS Dua to (or as e consequance of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BOURAL HEMATOMA 24b. Were autopsy tindings available prior to 24a. Wes an eutopsy performed? PERTENSION completion of cause of death? 2 DENO 1 Tyes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending invastigation Injury 1 ☐ Yas 2 ☐ No 3 Suicida

Examiner Examiner physician and s the bunal-transit that the death certificate be executed Box 68760. P.O. Records, The lew requires certificate Division of Vital or Attending Physicism: after death.

Director: After this certifica director Certification: To funeral 2 filled in

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or flame 23a or 28a-f show the Medical Exampler must be notified at

deeth

Peges 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or its

permit. Peges 1 end 2: Department of Health er important: if Item 27 is any Injury or other traughts.

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

Be

Physician/Medical by Completed Be

25. Was case rafarred to medicel axaminer? 1 Yes 2 No 27. Mannar of Death

6 Could not be datarmined

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifiar (Check only one)

4 Homicide

1) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signatura and title of continue

PIAZ MD

-000

29d. Date signed (Month, Day, Year) 9,2000

BALTIMORE, MD

of Plirson who completed causa of death (Itam 23a) (Type, Print) DIAZ, MD LUIS A

HOPKINS HOSPITAL JOHNS

State Registrar

Medical

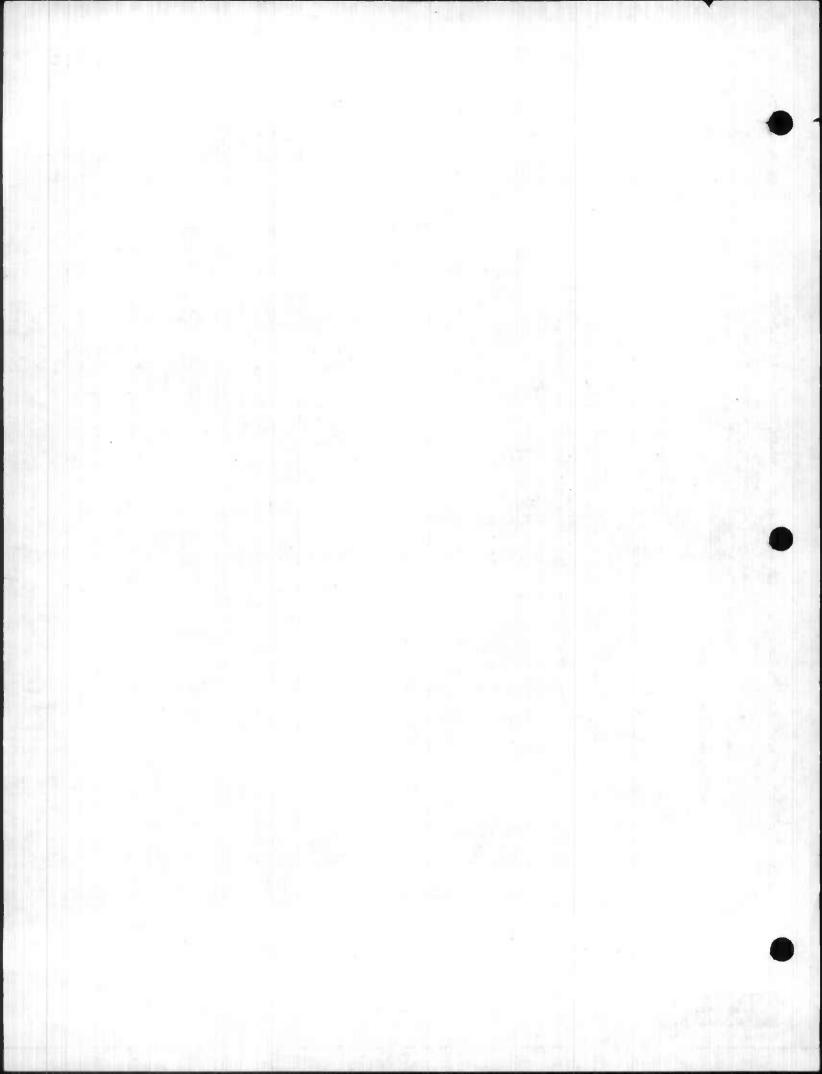
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32. Registrer's Signatura oaks

**DHMH 16 Rev 6/95** 

24 hours a Hospital

completely within 2 ş



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Dey **Physician** Albert Edward Anders 2000 April 10, 10:45 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7751 Wynbrook Road Colgate Baltimore 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Months Deys Hours Yrs. 415-07-9714 Director 78 May 4, 1921 Tennessee Usual Rasidence of Dacedent the Maryland 10a. Stata show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Directo Maryland Baltimore Colgate 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 7751 Wynbrook Road 21224 United States Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Stetus Black, Whita, atc. a filed within 72 hours after if Hygiene. other then "netural", or ite 1 Nevar Merried 2 Married 21215-0020 1 Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working title. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) College (1-4or 5+) 6 Years Camera Man WBAL TV Baltimore, Maryland permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important. If Nem 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Lewis Anders Clara Johnson 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) Connie L. Grasser (Daughter) 912 Virginia Avenue Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □Donation 5, E) Othar (Specify) Entombment Holly Hill Mem. Gdns. 4/13/2000 Middle River, MD 22. Nama and Addrass of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funaral Sarvice License 7922 Wise Ave. Dundalk, Maryland 21 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Use only one cause on sech lina. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaesa or condition rasulting In death) Non Small cell Leing cance Examiner Dua to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificata be axacuted attending physicien and for use as the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or es a consequence of): Box 68760. that initiated evants resulting in death) Last Dua to (or as a consequence of): signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was en eutopsy 1 Yas 2 No certificate of Vital Hospital or Attending Physician: director, 25. Was case rafarred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this Juneral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? After Division 5 Panding investigation 1 Natural after death. 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) lilled in by 4 Homicide 24 hours 156-Certifying Physician: To the best of my knowledge, death occurred at the tima, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. within 24 hour To the Funer completely Ill 29a, Cartifian ŝ

State Registrar

6830 HOSpetal 32. Registrants Signatura

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chue,

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

seea

29c. License number

145530

29d. Date signed (Month, Day, Year)

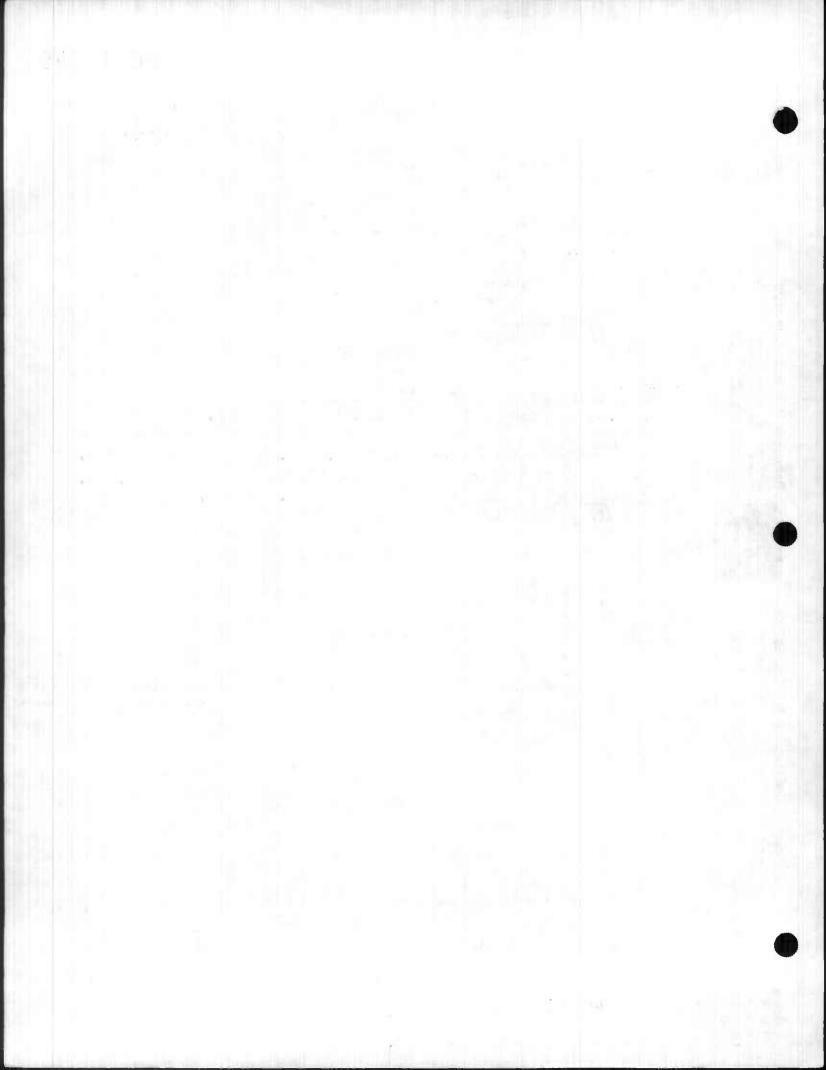
April, 10, 2000

206, Baltinore, ND 21237

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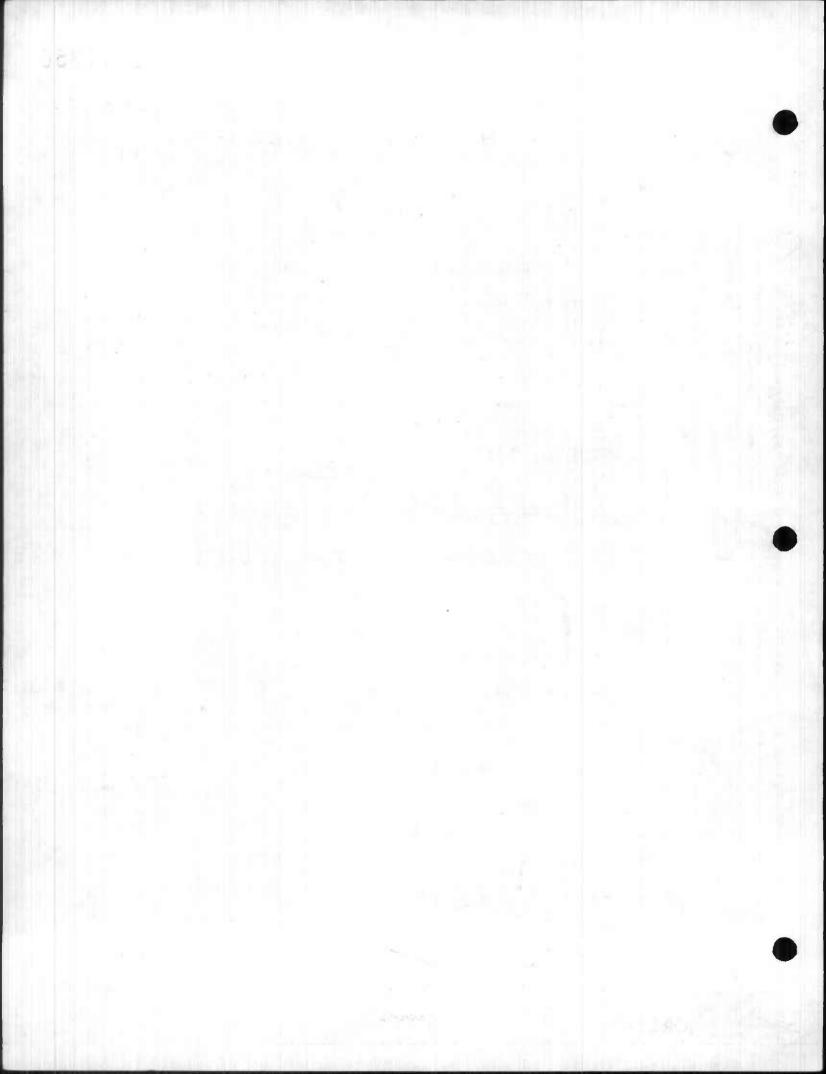
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. t. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** 12:20 AM APRIL JOSEPHINE C. BAUER 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSEDALE SQUARE HUSPITAL LENTER FRANKLIN ALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2₽F 52 Yrs. Director 212-46-9389 MAY 21, MD. Usual Residence of Decedent 10a. State 10c. City, Town or Location Items 23s or 28s-f show ner must be notified at 10b. County t Od. Inside City Limits BALTIMORE **ESSEX** MD. 1 Yes 2 No Director t On Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 321 ST. GEORGE ROAD UMUEA Maryland 21215-0020 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Bleck, White, etc. filed within 72 hours efter 1 Yas 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married netural', or 1 Yes 2 No Specify: Specify: WHTTE þ 3 ☐ Widowed 4 ☐ Divorced Completed t6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (t-4or 5+) HOMEMAKER OWN HOME 10TH 17. Father's Name (First, Middle, Last) t8. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked oth any lojury or other treumatic event abds. 8 VIRGINIA MARTHA McCHESTNEY JOSEPH W. JAZWINSKI, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 ST. GEORGE RD., ESSEX, MD. 21221 JOSEPH A. BAUER, SR./HUSBAND 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (name or cemetery, crematory or other place)

BALTIMORE WASHINGTON CREMATORY

22. Name and Address of Facility 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LAUREL. MD. pallure of Funeral Service Licen CHARLES S. ZEILER & SON, eds 1 1000 21 6224 EASTERN AVE., BALTIMORE, MD. 21224 23a. Paint1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical · CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 2 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: 8 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: t Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 RNatural 5 Pending 1 Yas 2 No deeth. To the Hospital or Attendi within 24 hours star death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29c. License number 29b. Signature and title of certified 29d, Data signed (Month, Day, Year) med cause of death (tem 23a) (Type, Print) 30. Name and address of p KERSHNER 9000 FRANKLIN SQUARE DRIVE BALTIMORE MARYLAND 21237 DAWN W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oorks APR 1 2 2000

Registrar DHMH 16 Rev 6/95

**ORIGINAL** 



Registrar

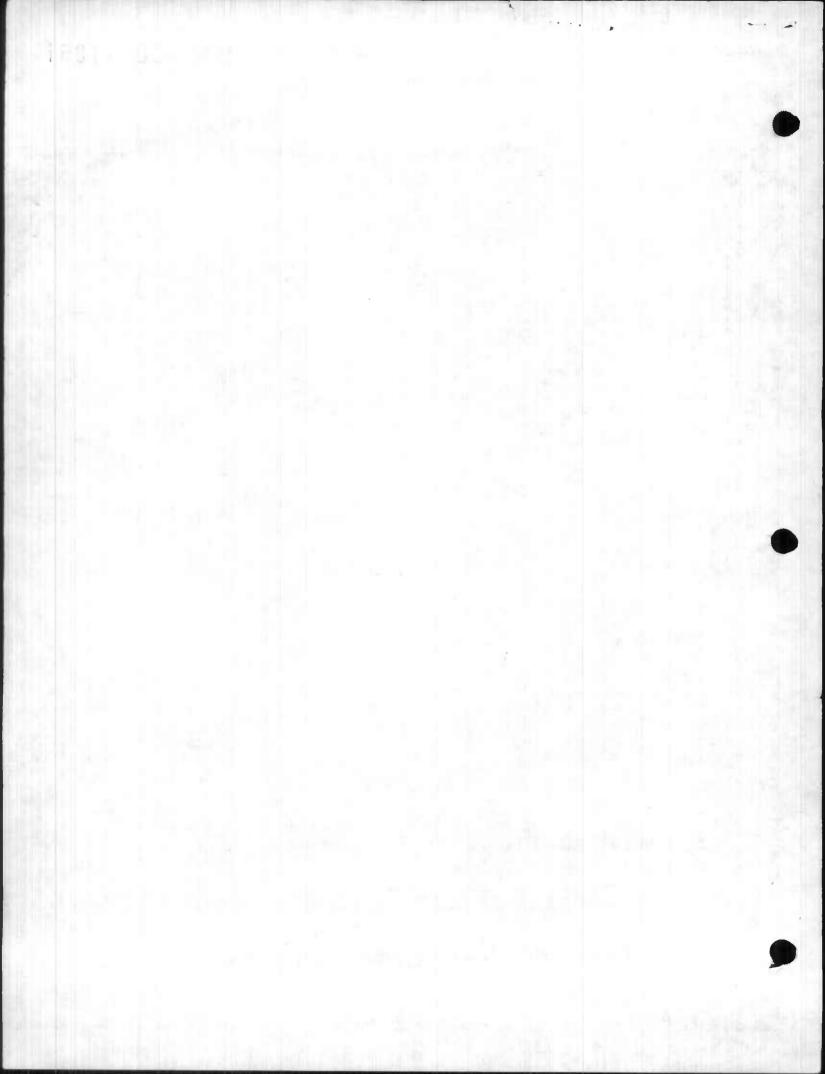
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Strphen S.
31. Dete filed (Month, Dey, Year) APR 1 2 2000

111 Penn Street, Baltimore, Maryland 21201 adent2 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (Itam 23e) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Elmer E. Braxton 2000 /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a BA / T Under 24 Hrs. Agues HOSPI more If Linder 1 Year 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 6. Sex Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 XX 20 F Yrs. 7-05-1185 Director April 25, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nes 2□No Director Md. n/a Baltimore or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3128 Piedmont Avenue 21216 USA 238 Funeral Hems 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married 1 ☐ Yea 2√ No If Yes, Give 21215-0020 b 1 Yea 2 No Specify: Specify: Black ğ 3₩idowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Dept. Education School Engineer 12th Grade altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be next of Health and Mental William Braxton Ella Cox 19a. Informent's Name/Relationship (Type, Print) N/CC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 3210 Yosemite Avenue Baltimore, Md. 21215 Lock/ey important: If Item 27 any Injury or other to Ulase 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State April 11 Baltimore, Md. Arbutus Memorial Park 21. Signature Funeral § 22. Name and Address of Facility Nutter Funeral Homes, Inc. wolcol bicense 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examine Examine Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underfying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to tenth but not soluting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 20 1 Yes 3 Probably 4 Unknown No signed b þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. tnjury at Work? 28b. Time of Certification: 5 Panding investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDNEL 31. Date filed (Month, Day, Year) 32. Registrer's Signature State APR12 2000 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Month 14:13 HRS OT 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street, and number) 4c. County of Death SAMARITAN BALTIMORE If Under 24 Hrs. A If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Data of Birth (Month, Day, Days Months Hours 10 M 20 F 217-18-5036 Usual Rasidance of Decedant 10a. Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location MD 1 Yas 2 No NIA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3204 BAYONNE AVENUE USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) UK Collega (1-4or 5+) LLK ENGINEER C+P TELEPHONE 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) JOHN S. BERRY MARIE ROESSEL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARJORIE E. BERRY WIFE 3204 BAYONNE AVE. BALTO. MO. 21214 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata METRO CREMATORY BALTO, MO 4 ☐ Donation 5 ☐ Other (Specify) 04.11.00 21. Signatura of Funeral Sarvice Licensae 22. Nama end Addrass of Facility CREMATION SERVICES 5151 BALTO, NATL PIKE, BALTO, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immedieta Causa (Final HYPERKAL EMIA disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last CHRONIC Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

ician and burial-transit The law requires that the death certificata be executed physician s the burial Box 68760. 957 P.O. signed by the a Records, page 2 Division of Vital or Attending Physician: within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at

death v

Pages 1 and 2 should be filed within 72 hours after

Hygiene.

ment of Health and Mental Hy nt: If item 27 is marked ----y or other----

Department of Important: If any injury or page.

**Physician** /Medical

Examiner

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

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Physician/Medical þ Completed Be 1 Yas 2 No Certification: To 27. Mannar of Death 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29e. Cartifier (Check only

25. Wes casa rafarred to medical axaminar?

5 Panding Invastigation 6 Could not be determined

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stele) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

one) 29b. Signatura and titla of openior yourund

M.D.

29c. License number

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) APPIAH 6000

31. Data filed (Month, Day, Year)

32. Registrar's Signatura 2000

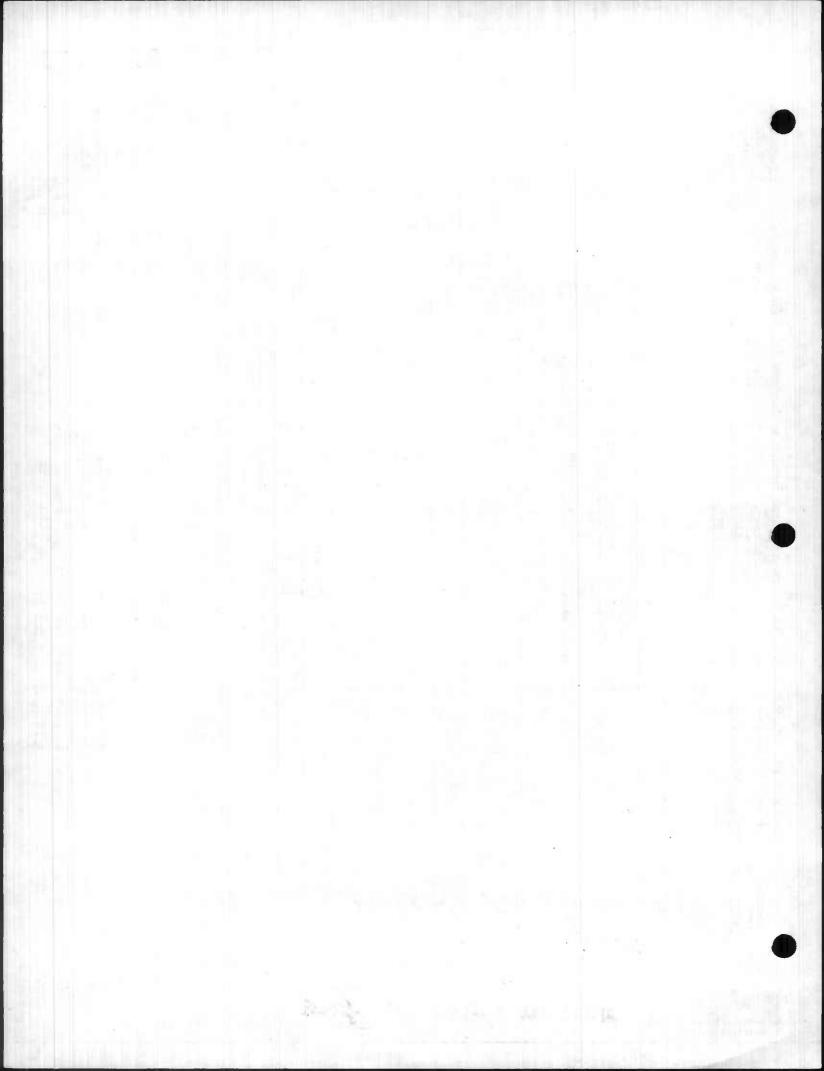
SAMARITANI HOSPITAL, BALTIMOR

State Registrar

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Hospital

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ch		(	Certificate o	f Death			Reg. No.		10.314					
1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Deeth Day Yeer		3. Time of Death					
Rita Lillian Ba	roch					March			1235 pm					
4a Facility Name (If not institution, give				4b. City, To	own, or Lo	cation of Deat								
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Social Security Number     6. Security Number		last birth	Months Dev		24 Hrs. Min.	8. Date of Bir (Month, De	th ev. Year)							
216-01-1882 Usuel Residence of Decedent	]M 20XF 81	Yı	rs.				8,1918 Maryland							
10a. Stete 10b. County	10c. Cit	ly, Town	or Location					10d.	Inside City Limits					
Maryland N/A		R=	altimore					10.19	1 N Yes 2 No					
10e. Street and Number		De	10f. Zip Code				10g. Citizen of V	What Country	?					
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	12. Was Decedent Ever in U	S.	13. Was Decedent o		rigin? (Spe	ecify Yes or No		a - American						
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3 Widowed 4 Divorced	If Yes, Give Yeer or Detes:	2 No ve 1 □ Yes 2 No Specity: Specity:					Whit	e						
15. Decedent'a Edu	cation	16a. D	Decedent's Usuel Occ	cupation			16b. Kind of B	usiness/Indus	itry					
(Specify only highest grade Elementery/Secondery (0-12)	completed) College (1-4or 5+)	9	Give kind of work dor life. DO NOT use ret	ne during mos ired)	st of work	orking								
12th. Grade	College (1-4or 5+)		Supervisor				Federa	1 Gov'	t					
17. Father's Neme (First, Middle, Last)			Jupet VISOL	18. Mother's Neme (First,		(First, Middle	st, Middle, Maiden Sumeme)							
Rudolph Ba	roch			Fmm			Hi	rt						
19a. Informent's Name/Relationship (Ty		19h. l	Meiling Address (Stre	Emm		I Route Numb			ode)					
Richard Vopalecky 20a. Method of Disposition	20b. F	Place of E	7107 Green Disposition (Name of		ve	Baltimo Dete	re MD 20c. Location	21206 City or Town						
1 Burial 2 ☐ Cremation 3 ☐ R	temovel from Stete	cametery,	, cremetory or other p	olaca)	1				, 5.5.5					
4 Donetlon 5 Other (Specify)	Mos	st Ho	1v Redeem	to Burial 2 □ Cremation 3 □ Removel from Stete										
21. Signature of Funeral Service License						1/2000	Dalt	Imore	MD					
	00 // /		22. Name end Add	dress of Fecil	ity		Dalt	imore	MD					
Mark m	Bl. 1-		John C.	dress of Fecil Mille	ity r, I	nc.								
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State Registrar

DHMH 16 Rev 6/95

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Dey, Year)

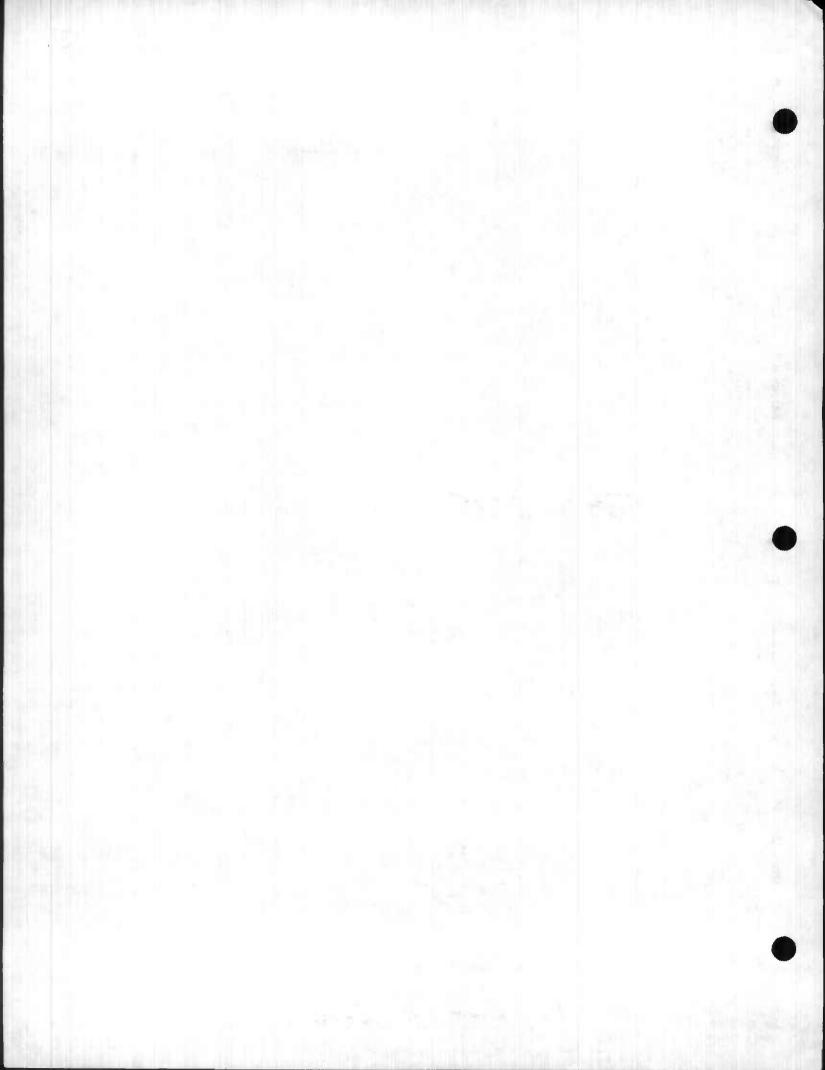
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 0320 Clark 170 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Butting If Under 24 Hrs. Hours Min. B. Date of Birth (Month, Day, Year) MAY 09, 1934 Mercy Hospital Bartmorecity if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 65 Yrs. Months Days 1KM 20 F 215-30-7254 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3108 AVENUE USA. 14. Race - American Indian, EIGHTON 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+HGRADE WORKER STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) CLARK LZEL ALVERTA MONROE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 3108 LEIGHTON AVE. BALTIHORE, MD. 21215 ce of Disposition (Neme of Date 20c. Location - City or Town, State VIRGINIA CLARK 20b. Place of Disposition (Name of cometery, cremetory or other place) 20e. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State MT. ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 14-11-00 LANSDOWNE, MARYLAND 21. Signature Human Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29 Immediate Cause (Final disease or condition resulting in deeth) SUDSIS oremonth Due to (or as a consequence of): reporte talle Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury yeers CITCHOSIN that initiated events resulting in death) Lest Due to (or es a consequence of) Part fl. Other signiffcant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide

Box 68760. P.O. Records. **Physician** 

\* /Medical

Examiner

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**Funeral** 

Director

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29e. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number P12443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U. Of MUN Jund 29d. Date signed (Month, Dey, Year)

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Heather o mannuel mb State

31. Date filed (Month, Day, Year)

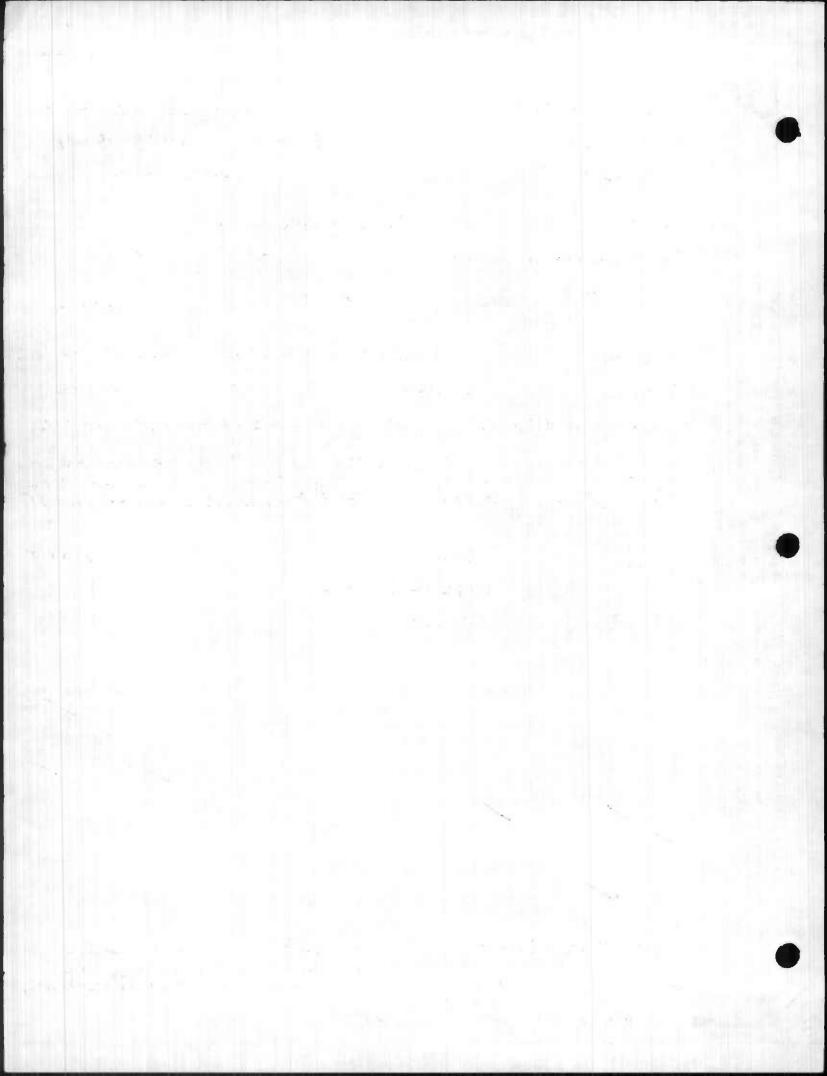
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32. Registrar's Signature

22 S. Greene Street Bathmore MO21201 sarks

DHMH 16 Rev 6/95

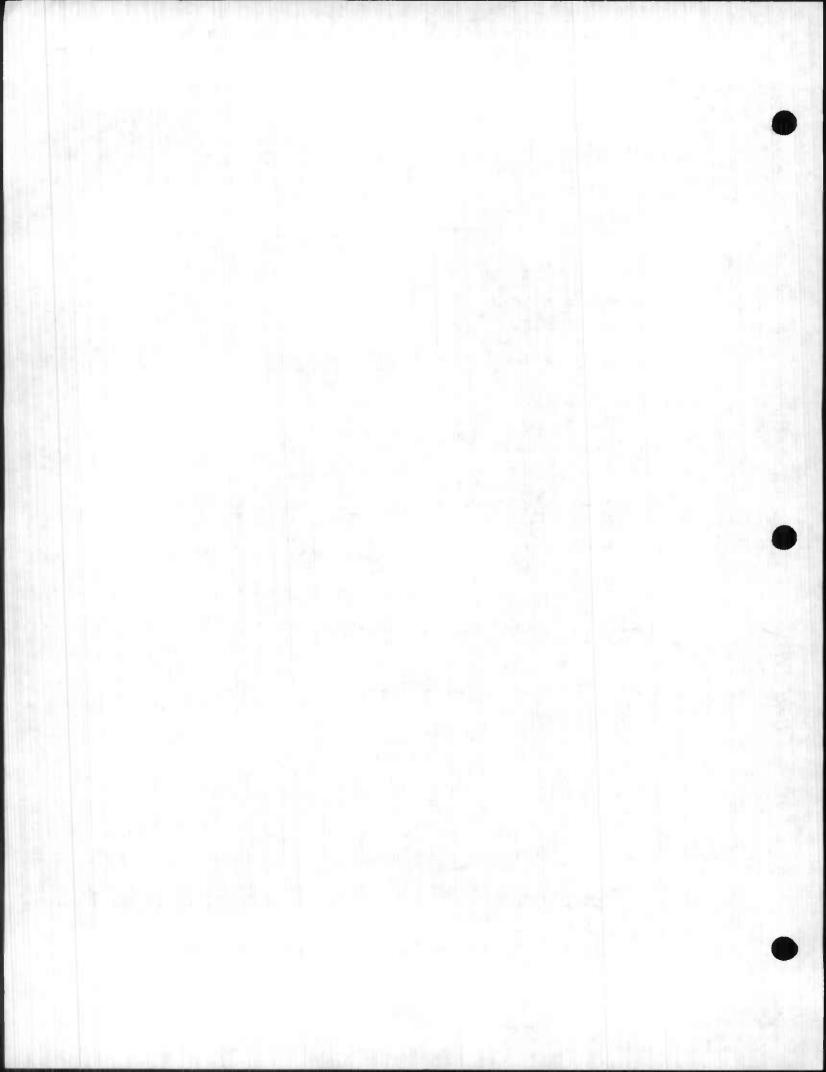
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State of Maryland / Department of Health and Mental Hygiene O O

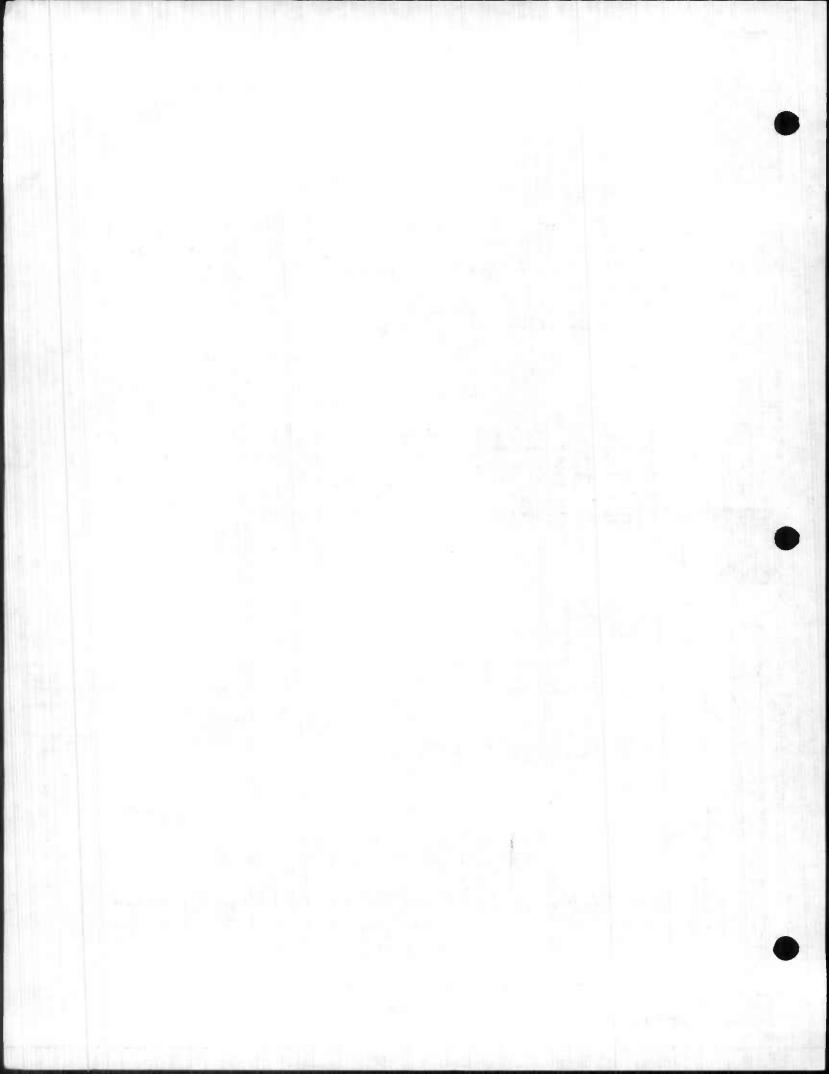
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215	10e. Street and Nur	mber				10f. Zip Cod		10g. Citizen of \		y?	
2010	3224 Rich	nfield		21131 Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Sp.				Crasife Van as N	US		a ladiac
27 - 211011	11. Marital Status  1 Never Marri 3 Widowed	Armed F 1 Tes If Yes, G	was becoom Ever in U.S.  If Yas, specify Cuban, Mexican, Pt If Yas, Siere  If Yas, Specify Cuban, Mexican, Pt If Yas, Siere  If Yas, Specify Cuban, Mexican, Pt If Yas, Specify Cuban, Pt I				orto Rican, etc.)  Bleck, Whi  Specify:			c.	
	10-	15. Decedent		0	16a. De	ecedent's Usuel Oc	cupation	advisa	16b. Kind of B	Whit usinass/Indu	
2000	Elementary/Seco		t grade completed College	oge (1-4or 5+) life. DO NOT use retired)							
	17. Father's Nama	/Einst Middle I	5.	+	Sc	hool Teac		ame (First, Middle	tion		
			Miller				Mary		audenkla		
2	19a. Informant's Na	_		-	19b. N	lalling Address (Str	eet and Number or F				Code)
	Mr. Elme	r S. Co	chran/hu	sband	322	4 Richfie	ld Lane P	hoenix,	Md. 2113	31	
	20a. Mathod of Disp		3 □Removal from	State	cemetery,	isposition (Neme of cremetory or other	plece)	Dete	20c. Location		n, Stata
	4 Donation				Hilltop	Service		4/12/00	Towson	, MD.	
	21. Signiffso of Se	2 Cota	2000	D	-		dress of Facility Son Funer Rd. Tows				
edical Examiner	disease or condition resulting in death)  Sequentially list conificant, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, nmediate rhying injury	b	Du	e to (or as a cor	nsequence of):	ONARY DIS				
	Pert It. Other signif	icant condition	d	death but n	ot resulting in th	ne underlying cause	given in Pert I.	23b. Dio	I tobacco use co	ntribute to t	the cause of death
								1	1 Yes 2 No 3 Probably Tunknow		
									s en eutopsy formed?	avai	a autopsy findings lable prior to pletion of cause eath?
								1	Yas 210 No	10	Yes 2□ No
	25. Wes case refer	red to medicat						eeth (Check only	one)		
	1 Yes 20 27. Manner of Death Natural 2 Accident	5 Pending investig	28a. Date (Mon	tnpatient of tnjury oth, Day Y	2 ER/Outpe 28b. Tim tnju	e of 28c. I	Other: 4 Nursing njury at Nork? I Yes 2 No		idence 6 KOth how injury occur		HOSPICE
	3 Suicide 4 Homicide	6 Could no	200. Plac	e of Injury ding, etc. (	- At home, farm Specify)	, street, factory, offi	СВ		(Street and Numb own, Stata)	ber or Rural	Route Number,
Bollogi	29a. Certifier (Check only one)		xaminer: On the I		amination and/o		e tima, data and place by opinion, deeth occ				
THE STATE OF THE S	29b. Signature and	title of certifier	7				anse number 43725		29d. Dete signe	d (Month, D	lay, Year)
e	DR. TARI 31. Data filed (Mont	Q MAHMO	OOD 2300	DULA		LEY RD.	TIMONIUM	, MD 21	093		

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# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.0

E	Amended It	em#	8 perFHG78		EW			tificate of	Death		Reg. No.	JU	11858
п	Physicia	n	Decedent's Nem	e (FIRST, MICIONE, L	AST)					2. Dete of De Month	Dey	Yeer	3. Time of Death
4	/Medica			A. CULI						APRIL	_	2000	0109
	Examine	r	4a Facility Name (					4b. City, Town, or L	ocation of Deet				
1_		4		COUNTY				Hitlader 1 Vos	COLUMBIA HOWARD  1 Year   If Under 24 Hrs.   8 Date of Birth 10/1 9 Birthole				
	Funeral Director		5. Social Security N 220-36-05	563	Sex 1√2 M 2□ F	7. Age (In yrs. 59	Yrs.	Montha Days			th <sub>Year)</sub> 1941 25, <del>20</del> 0		plece (Stete or Foreign ntry)
	ehow ed.m	-	Usuet Residence o 10a. State	10b. County	Location 10d. Inside City Limits								
	Me Mer	Director	Md.		ward			Colur	nbia				1 Xes 2 □ No
	72 hours effer death v *naturel*, or terms 23a deal Estan he must	rai Cir	7306 Car						21045		USA		
020		2	11. Maritat Status 1 Never Marr 3 Widowed	ied 2 Merried	12. Wes Dec Armed Fo 1 D Yes If Yes, Gi Year or D	2 □ No		Ves Decedent of f Yes, specify Cu I ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	ce - Americ ck, Whita,	etc.
21215-0020		mpiered	(Spec	15. Decedent's li cify only highest g andary (0-12)		1-4or 5+)	(Give	lent's Usual Occi kind of work don OO NOT use retir al Agent	e during most of work ed)		16b. Kind of E		of Treasury
	filed with Hygiene. Wher there		17. Father's Neme	/First Middle Las	۷)		opeci	ar ngan	18. Mother's Nem				71 Treasury
lan	should be filed within and Mentel Hygiene. marked other then arratic event, the Mentel Hygiene.	0 20	Alto C. Cullings Anna M									,	
Maryland	2000		19a. Informant's N Anthony I	ACHIEL STATE		on			et and Number or Aur Randall				Code)
aitimore,	Department of Heelth Department of Heelth Important: If Item 27 any injury or other th			position  Cremation 3   5 Other (Spec		State	cemetery, cren	sition (Name of natory or other pi Memoria)		Dete pril 14	20c. Location Baltim		
Bait	permit. Pag Department Important: I any injury o		21. Signature of Fu	est R	anso	le.		Name and Add	ress of Facility Nuns Falls P		neral H timore,		
	Physician		23a. Part1. Enter t shock, or hea	he disease, or con int failure. List only		caused the dea		_	ring, such es cardiec				Approximate Interval Between Onset and Deeth
7	/Medical Examiner		Immediate Cause disease or condition	(Finet	PROB	ABLE M	OCARDI	AL INFA	RCTION			1	2 HOURS
			resulting in death)		CORC					20 YEARS			
	cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate									1	.0 TEARD
ox 68760,	ficate be physicia as the bur	0000	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or ea e consequence of):										
Box	0 0 2 7	ruysiciarum	Part II. Other eignit	icant conditions	contributing to d	eath but not res	ulting in the ur	nderlying cause g	given in Pert I.	23b. Did	tobacco usa co	ontribute t	o the cause of death?
P.O.		Dy PHY	HYPERGL	YCEMIA						100	1 No 3 Probably 4 Unknow		
Records,	has been sigge 2 should b	Paradillos									an autopsy ormed?	64	ere autopsy findings alleble prior to empletion of cause deeth?
Œ	The la	5								10	Yes 2 No	11	☐ Yas 2☐ No
Vitai	Physician: The ribis certificate ral director, page		25. Wes casa refer	red to medicat					26. Place of Deel	th (Check only	one)		
of V	0 0	0	1 ☐ Yes 2 ☐	No	Hospitat:	Inpatient 2	ER/Outpatien	1 3LI DOA		ome 5□ Resi	dence 6 🗆 Ot	ner (Speci	(y)
Division o	Attending Ph r death. ector: After th by the funeral	Cer till Cation.	27. Manner of Deat 1 ☑ Naturat 2 ☐ Accident	5 Pending investigation	on	of Injury th, Day Year)	28b. Time of Injury	28c. Inj W M 1[	ury et ork? ] Yes 2 No	28d. Describe	how injury occu	rred	200
Divis	tord rect		3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	208. Place	of Injury - At h ng, etc. (Speci	ome, farm, atn fy)	eet, factory, office		28f. Location ( City or To		ber or Run	al Route Number,
	in 24 hours he Funer plately fill	200	29a. Certifier (Check only one)		miner: On the b				time, date end plece, opinion, deeth occur				
	within To the	E	29b. Signeture and	certifier	ly				29d. Dete aigned (Month, Day, Year) APRIL 10, 2000				
	2		30. Name and addr	AKLI, M.	- 100			*	COLUMBIA,	MD 210	044		
	State Registra		31. Date filed (Mon	th, Day, Year)		legistrar'a Sign		aks.					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death Amended Item#12,18 perFHG782 4/25/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death **Physician** DONAL APRIL 1845 2000 /Medical 4b, City, Town, or Location of Deeth 4c, County of Death 4e Fecility Name (If not Institution, give street and number, Examiner Daltimore BALTIMORE St Agnes Hospita 5. Sociel Sectrity Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Deys 216-28-1119 68 Yrs. **Director** Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Funeral Director 10e. Street and Number 274 Blakeney RD 10g. Citizen of What Country? 10f. Zip Code 21228 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "naturat, or items 23. any Injury or other treumatic event, in Marian Examiner main 12. Was Decedent Ever in U.S. Armed Forces? 1952— 1 Xves 2 No 1954 Ifyes, Give Veer or Detes. Korcess: War Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: White by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) MACHINIST 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Cote UNKNOWN NOWN 19b. Mailing Address (Street end Number or Rura) floute Number, City or Town, Stete, Zip Code) 9e. Informent's Neme/Reletionship (Type, Print) 20b. Plece of Disposition (Neme of cometery, cremetory or other) 20e. Method of Disposition 20c. Location - City or Town, Stete Important: If he eny injury or conce. 1 Deuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) FUNERAL HOME, INC 21. Signature of Funeral Service Licensee 1630 Edmondson dre 191 Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) ABDOMINAL AORTIC ANEURYSM Examiner Physician/Medical Examiner physician and s the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 50 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed certificate has b lirector, page 2 sl 2 12 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 1 Dinpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deatl Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. edical (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 24 To the To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

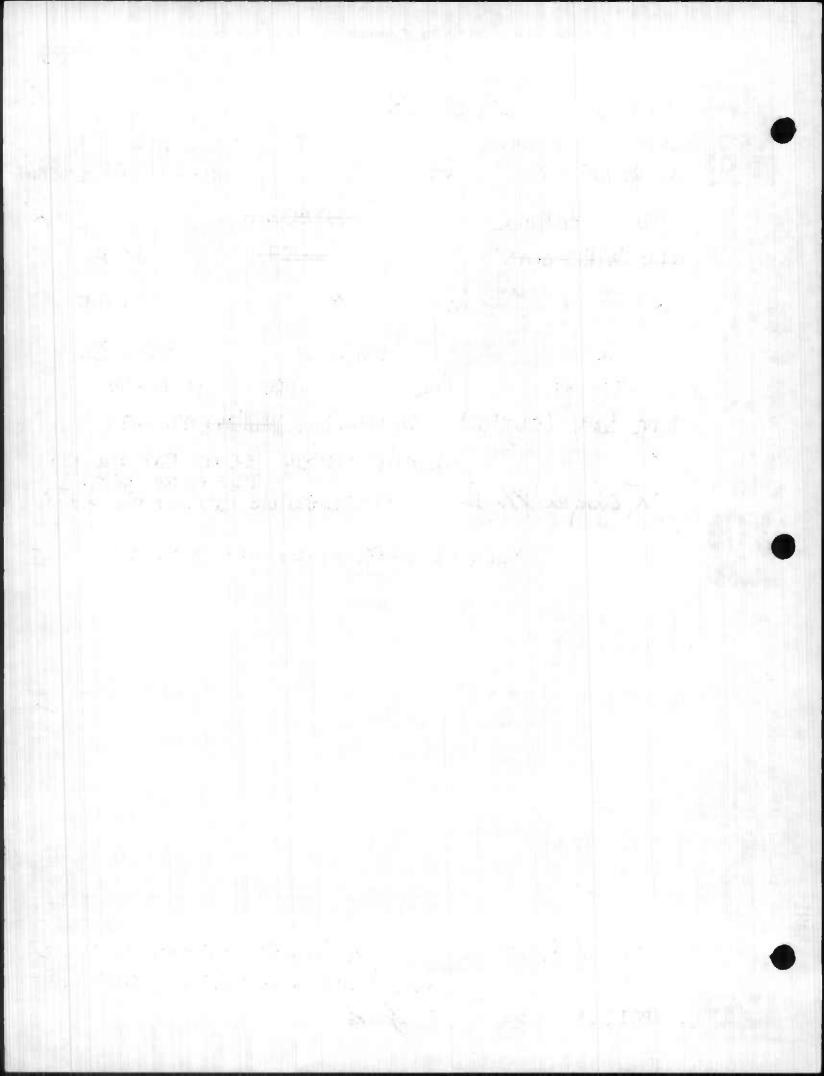
Registrar

31. Dete filed (Month, Day, Year)

2000

APR 12

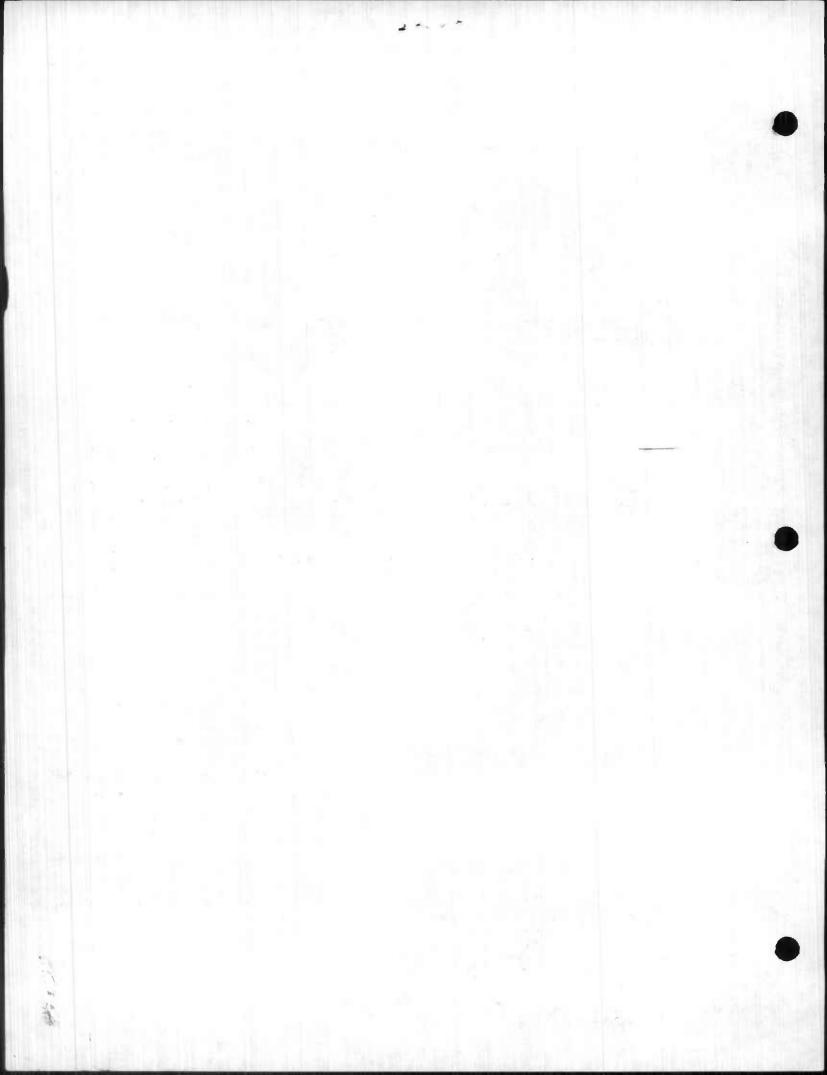
32. Registrer's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11860 AMENDED ITEM #20a PER FH G782 4/12/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 04 AM 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balfmore HUnder 24 Hrs. 8. C MIVERSIN Elicion Inne 6. Sex If Under 1 Year 8. Data of Birth Month, Pay, Year) 10/18/44 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 □ M 2 # F 55 218 44 0566 MD. Director Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1# Yes 2 □ No MD BALTIMORE Director 288-7 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21217 2229 OREM AVE. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. AFRO 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Naver Merriad 2 Married Yas 2# No f Yes, Give altimore, Maryland 21215-0020 8 1 ☐ Yes 2 #No Specify Specify: AMERICAN by 3##Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) HOMEMAKER HOME 17. Falher's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be MARY F. BANKS CHARLES BANKS 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or of Health as ret: if flam 27 is MIDWOOD AVE. BALTO. MD. 21212 5332 OAKS MARY 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Dete METRO CREMATORY Duniar 2 10 Cremation 3 Removal from State 4-8-2000 CATONSVILLE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
ESTEP BROTHERS FUNERAL HOME
1300 EUTAW PL BALTO. MD. 21. Signature of Funeral Sarvice Licensee 21217 23a. Part1. Enter the disease, or complications that caus shock, or heart feilure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner 1 2 Yas Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medicai Certification: To Designation 2 ER/Outpatient 3 DOA 2 □ No this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifler 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Dev. Year) 2000 pleted cause of deeth (Item 23a) (Type, Print) Greene Storet, Baltimin South 32. Registrer's Signature 31. Data (Month, Day, Year) 2000 APR 1 2 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** Aura Dale Cook 5:00 a.m. April 10 2000 /Medical 4e. Feclifty Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Millennium at South River Anne Arundel Edgewater 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 M A F Months Hours 578-32-8404 Yrs. 102 Sept. 13,1897 Missouri Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3941 Mill Pond Road 21037 IISA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes ZXNo Specify: White p 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Quartermaster Elementary/Secondary (0-12) College (1-4or 5+) General's Office Administrative Officer 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nancy J. Redd Turner B. Mahoney 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Holleman (Nephew) 3941 Mill Pond Road, Edgewater, MD 21037 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 04/11 2000 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Move than Immediate Cause (Finel STENOSIS. diseese or condition resulting in death) 1 year more than Examiner HEART DISEASE HTHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown RENAL INSUFFICIENCY. by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy performed? Be Completed DEMENTIA. 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653 4-10-2000

GYAN . C. SURAWA

Road Deale mD.

Within 2 To the 1

Registrar

5851-

APR 1 2 2000

30. Name and eddress of person who completed ceuse of deeth (item 23e) (Type, Print)

DealeChurchton

**Funeral** 

Director

28a-f show

itams 23a or 28a-f shov iner must be notified at

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"natural",

filed within 7 Hygiena.

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oths any injury or other treumatic event

**Physician** 

/Medical

**Examiner** 

tha

signed I

cartificata

Hospital or Attanding Physician: 724 hours aftar daath. Funeral Director: After this cartifica titaly filled in by the funeral director, p.

in 24 hours after the Funeral Dir npletaly filled in

that the death certificate be axecuted

Box 68760.

P.O.

Records,

Division of Vital

tha Maryland

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Theodore F. Cord 3:39 p.m. April 7 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 15 M 2□ F 577-40-6686 Director Jan. 5, 1933 Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location ahow! 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Director Anne Arundel Millersville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 1133 Dicus Mill Road 21108 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: Korea 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer cannot of health and Mentel Hygiene.
ant: if item 27 is marked other than "natural", or health yor other traumatic avent, the legical Earn in try or other traumatic avent, the legical Earn in 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Liquor Sales 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) Be Henry W. Cord Elizabeth Nicholson 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Cord (Wife) 1133 Dicus Mill Road, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/11 permit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2000 Baltimore, MD 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ANELIESYNT WEEK Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien s the burial Physician/Medical Due to (or as a consequence of): signed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Winknown ARTERY DISEASE 1 Yes 2 No by 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy performed? OUESTEROLEMUM completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 BER/Outpatient 3 ☐ DOA this 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Statural
2 Accident

Division of Vital Records. P.O. Box 68760.

or Attending Physician: funeral After No Hospital or Attanding in 24 hours after death. The Funeral Director: After filled in t

To the Hosp within 24 hos To the Fune completely fi Medical

> State Registrar

29b. Signature and title of certifie

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 4/10/00

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDI VETERANS Huy #204 MILLERSVILLE, ND 21108 BIDDLE 1 (MOTHY

1 Yes 2 No

31. Date filed (Month, Day, Year)

3 Suicide

4 Homicide

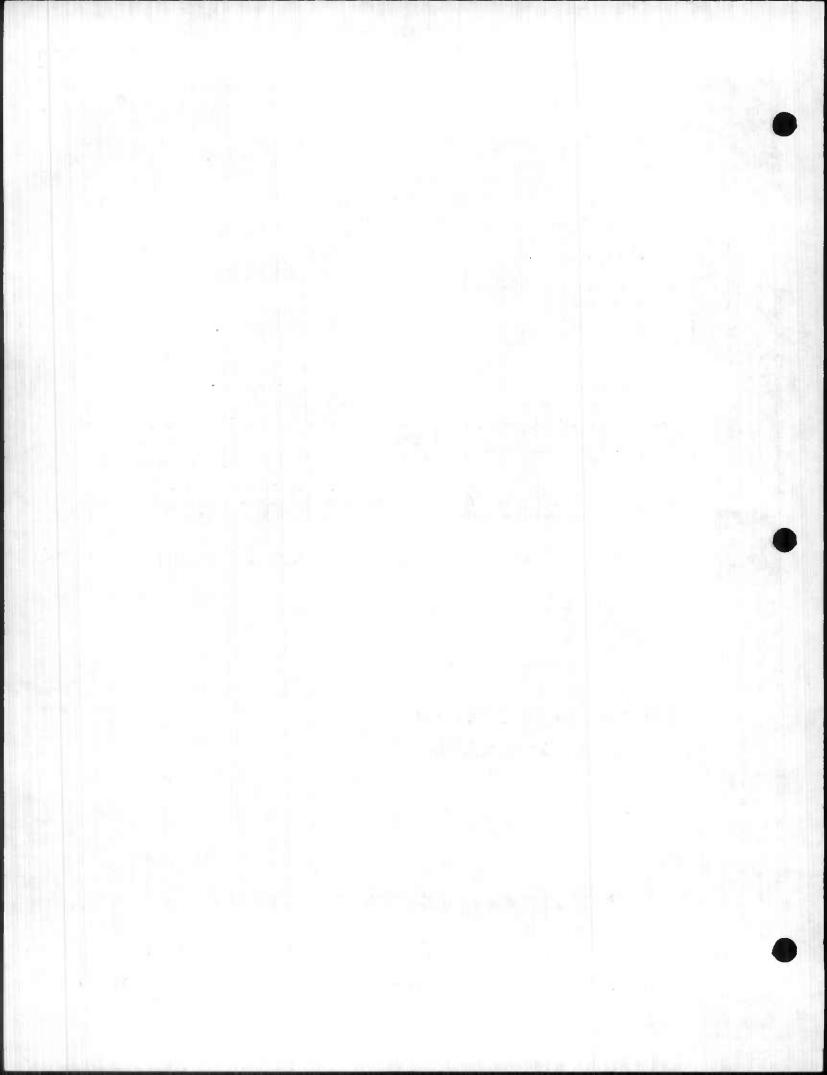
(Check only one)

29a. Certifier

APR 1 2 2000

6 Could not be

32. Registrar's Signature

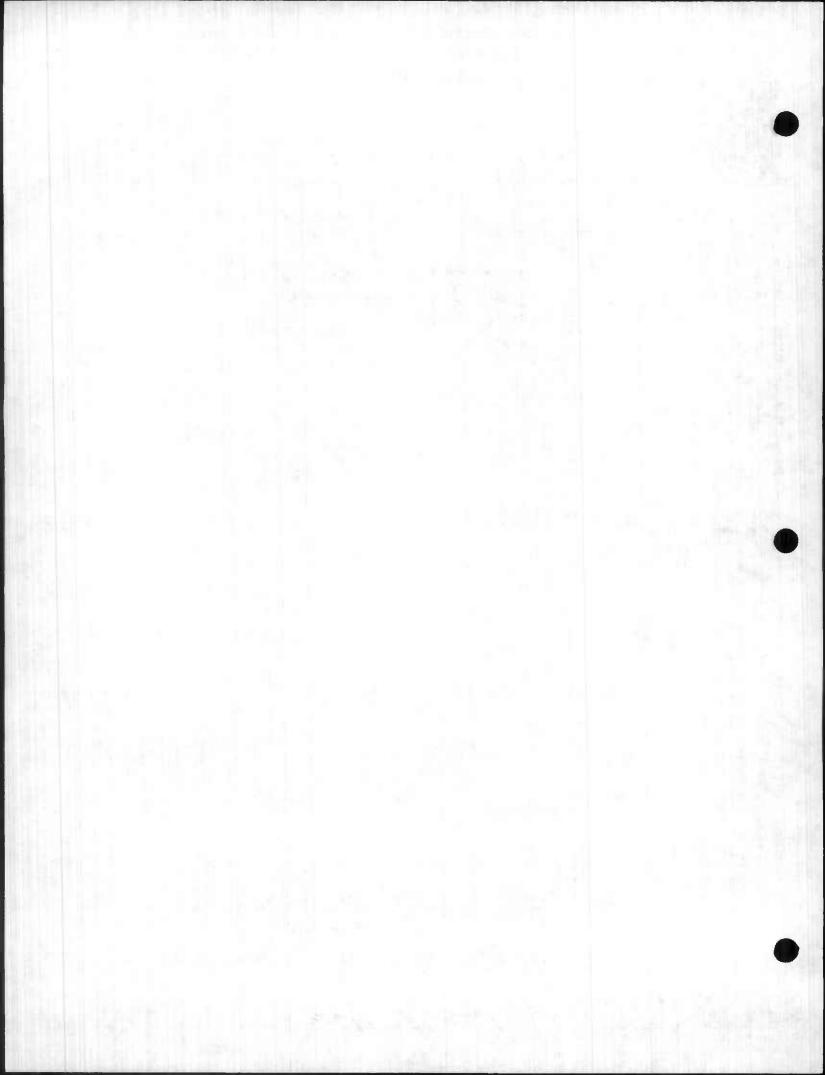


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State of Maryland / Department of Health and Mental Hygiene

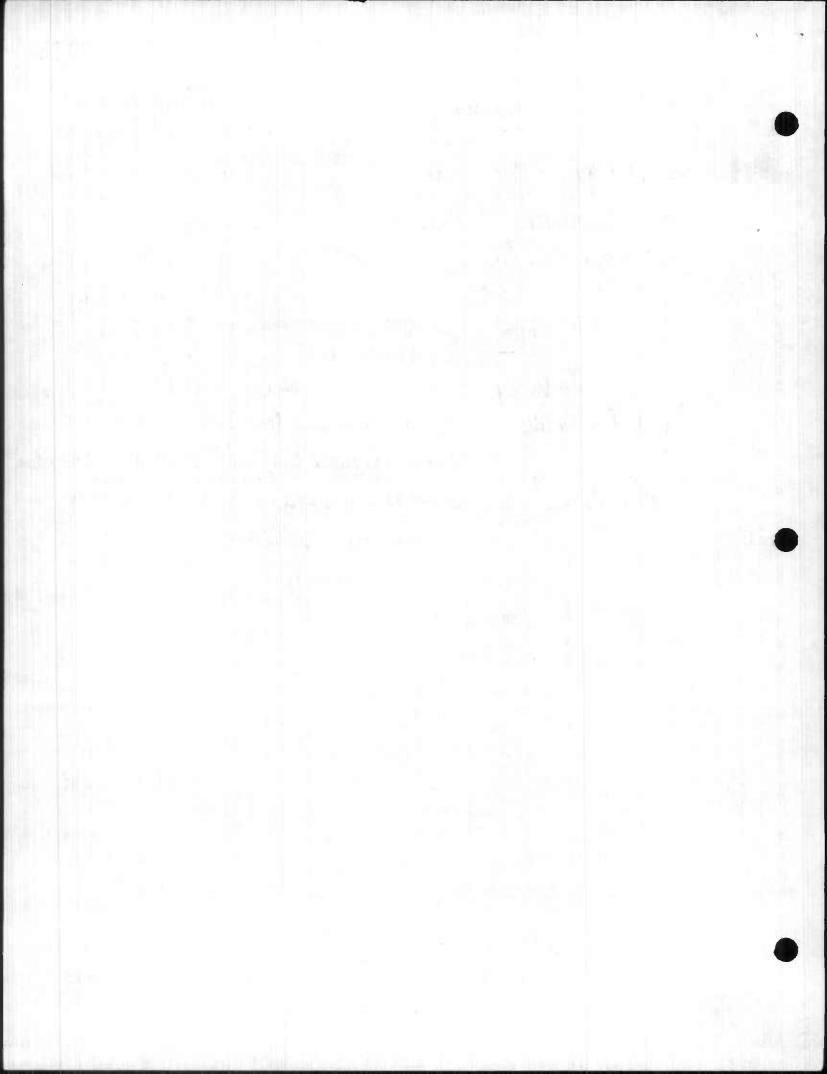
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xaminer	4a		if not institution, gh IOPKINS H		ber)				4b. City, Tow BALTI		cation of Deat		y of Death						
ineral ector	2	218-09-9214 1⊠M 2□F				(In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min					8. Date of Bir (Month, Da 5/6/19	of Birth h, Day, Year) 9. Birthplace (State or For Country) 1914 Pennsylvania			o <i>r For</i> e				
M 18	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits									
be notified at Director		Md.	N/A	Baltimore							1 <b>X</b> ₩es 2□								
al Dir	100	331 Ham	<sup>mber</sup> ilton Ave	nue		101. Zip Code 21206						10g. Citizen of What Country?  USA							
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		Elementary/Second 12	ondary (0-12)	College (1-	4or 5+)	Laborer						Steel	Compa	iny					
		Father's Name	(First, Middle, Last	)	18. Moth					r's Name	(First, Middle	Maiden Suma	me)						
A M	1	John Che	earno			Rose DiMe													
Tie marks traumatic To		a. Informant's N	10.	19b. Maili	ng Addres	s (Street	and Numbe	r or Rura	Route Numb	er, City or Town	n, State, Zij	Code)							
127 P	M	rs.Ann I	Marie Jen	sen-Daug	hter	12 0	hest	erfi	eld Ct	.Mon	kton,	Md. 211	11						
y or other	20a		Cremation 3		tate C	Place of Disponentery, crea	matory or	other pla		erv	Date 4/13/2	20c. Location		own, State					
injury 8.	21		5 Other (Special		du					- 4									
Important: It any injury or once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck Fur 5305 Harford Rd. Baltimore, Md. 212												ome						
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		State of Maryland	Certificate			Reg. No.	0 1100	4
Physician	1. Decedent's Nama (First, Middle, Las	Dunie			2. Data of De Month R I		3. Time of D	
/Medical Examiner	4a Facility Nama (If not institution, give Saint Joseph	street and number) Medical Cent	er	4b. City, Town, or I		4c. County	of Death Baltimore	
Funeral Director	10-01-0019	PX 7. Age (In yrs. las	t birthday) If Under 1 \ Months D	ear If Under 24 Hrs. ays Hours Min.	8. Data of Bir (Month, Da DLC 5		9. Birthplaca (State or Incountry) MAPYIANO	
Maryland and end and end end end end end end end end end e	Usual Residence of Decedent  10a. Stata  10b. County  A BAUW	100 Pa	Town or Location		•	10d. Insida City		
after death with the Marylen or flems 23s or 28s-f show infiner must be notified at a Funeral Director	10e. Street and Number 8609 Wilhd	ellAve	101. Zip Co		10g. Citizen of What Country?			
0 5 4 0	3 XWidowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert (No Specify:	pecify Yas or No o Rican, atc.)	Specify	e - Amarican Indian, ok, Whita, atc.	
THE C 1 S T	15. Decedent's Ed (Specify only highest grad	college (1-4or 5+)	16a. Decedent's Usual O (Give kind of work d life. DO NOT use n	ccupetion one during most of wor etired)	king	16b. Kind of Bi	usiness/Industry  19 COM.	
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Baltimore, permit. Pages 1 e Department of Hee Important: If Hem eny Injury or othe	1 Surial 2 Cremation 3 Care 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens	Mas Mas	HOLY RIGHT	ddrass of Facility	2000	Baltin	nope Mary	yland
Physician /Medical Examiner	23a. Part I. Enter the disease, or companies shock, or heart taiture. List only of temperature the control of t	VENTRICULA		ATION ARE		rrast,	Approximate Interval Betwee Onset and De	een eath
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DIVISION O To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	27. Manner of Death  1 Naturat 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	(Month, Day Year)	М	Injury at Work? 1 Yas 2 No		how injury occur		hav
DIVI	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	a, farm, street, factory, of	nce	City or To		er or Rural Route Numb	rer,
To the Hospital or within 24 hours efter To the Funeral Director Completely filled in Medical Cert	29a. Certifier 152 Certifying Phy (Check only one) 2 Medical Exam	reician: To the best of my knowle iner: On the basis of axamination and manner stated.						
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30	30. Name and address of person who c FRANCIS H. MOI	ompleted cause of death (Item 2 RRIS, M.D., 7	3a) (Type, Print) 76 211 OSLER	DRIVE TO	WSON,			
State Registrar	31. Date filed (Month, Day, Year) APR 1 2 2	32. Registrar's Signatur	· p pp	resta				



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	Physician /Medical Examiner	Decedent's Name (First, Middle, La LEO     General Section (Minot institution, given John's North Bayu)	re street and number	)	WE ICH	JR 4b. City, Town, or BALTIMO		FIGHT (	Year +000	ime of Death	
	Funeral Director	5. Social Security Number 6. S		ge (In yrs. last birtl 74 Y	Monthe	Year If Under 24 Hrs Days Hours Min.		th ly. Year) 1,1925	9. Birthplaca (S Country) MARYLAN	State or Foreign	
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21215	than 'nar ha Medio omplete	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 0	ducation ide completed) College (1-4or		Decedent's Usual (Give kind of work life. DO NOT use ROLLER	done during most of wo	rking		usiness/Industry  N STEEL		
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Mary Mary	aith and N 27 is man or traumen	19a. Informant's Name/Reletionship ( AMELIA L. DOTTER				Street and Number or RI					
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	hysician /Medical	21. Signature of Funeral Service Licer  23a. Part1. En or the disease, or compensation of learn failure. List only  Immediate Cause (Final	Selin	0	CHARLES 6224 EA ot enter the mode	Address of Facility S. ZEILER STERN AVENU of dying, such as cardia	E BALTI	MORE, M	Interv	21224 oximate el Between t end Deeth	
E	xaminer	disease or condition resulting in death)	a	Due to (or es a consequence of):  ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RESPONSE							
68760,	.25	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATRIAL	Due to (or es a co	onsequence of):	RAPID USI	VIR ICULAR	a stony		()44>	
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DIVI	olinector: Jin by the	3 Suicide 6 Could not b 4 Homicide determined	ZOU. PRICE OF ITS	jury - At home, fer ic. (Specify)	m, street, fectory, o	office	28f. Location ( City or To		per or Rural Rout	a Number,	

Medical Certification: To Be Completed by Physician/Medi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical exeminer?

is certificate has been signed by the attending phy director, page 2 ahould be detached for usa as th Funeral Ofrector: After this certificate has stely filled in by the funeral director, page 2

To the Hospital or Attending Physician: The law requires that the death certifica vithin 24 hours after death.

**DHMH 16 Rev 6/95** 

State Registra\*

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) RAYMOND 31. Dete filed (Month, Day, Year)

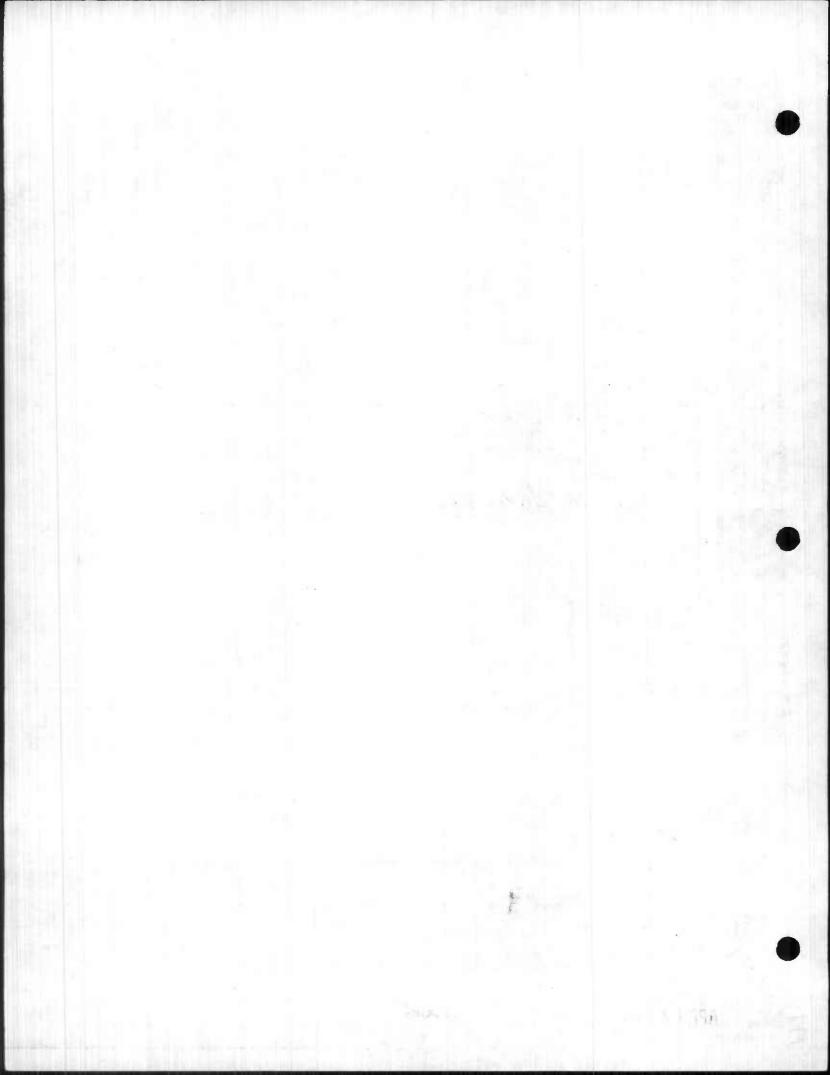
2000

29e. Certifier (Check only one)

ROBERT 32. Registrar's Signature 29c. License number 20318

29d. Date signed (Month, Day, Year)

4940 EASTERN AVENUE BALTO., MD MD.



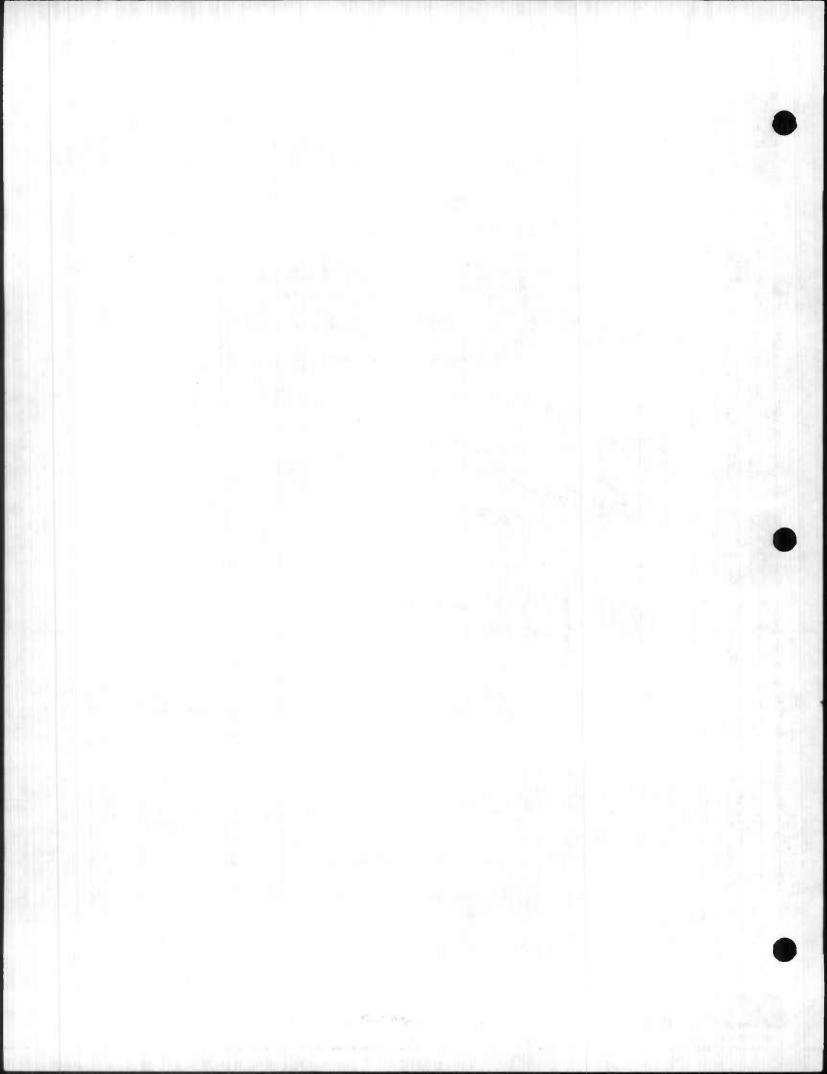
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician DRAWE CATHERINE MAY 04 00 01 /Medical 4a Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex HUSPITAL FALLSTON HAZFORD ER FALLSTON H Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

June 23, 1 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1□M 20 F 65 Yrs Director 218-28-3555 Maryland Usual Residence of Decedent the Meryland 10s State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1407 Brierwood Court 21085 U.S.A. deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

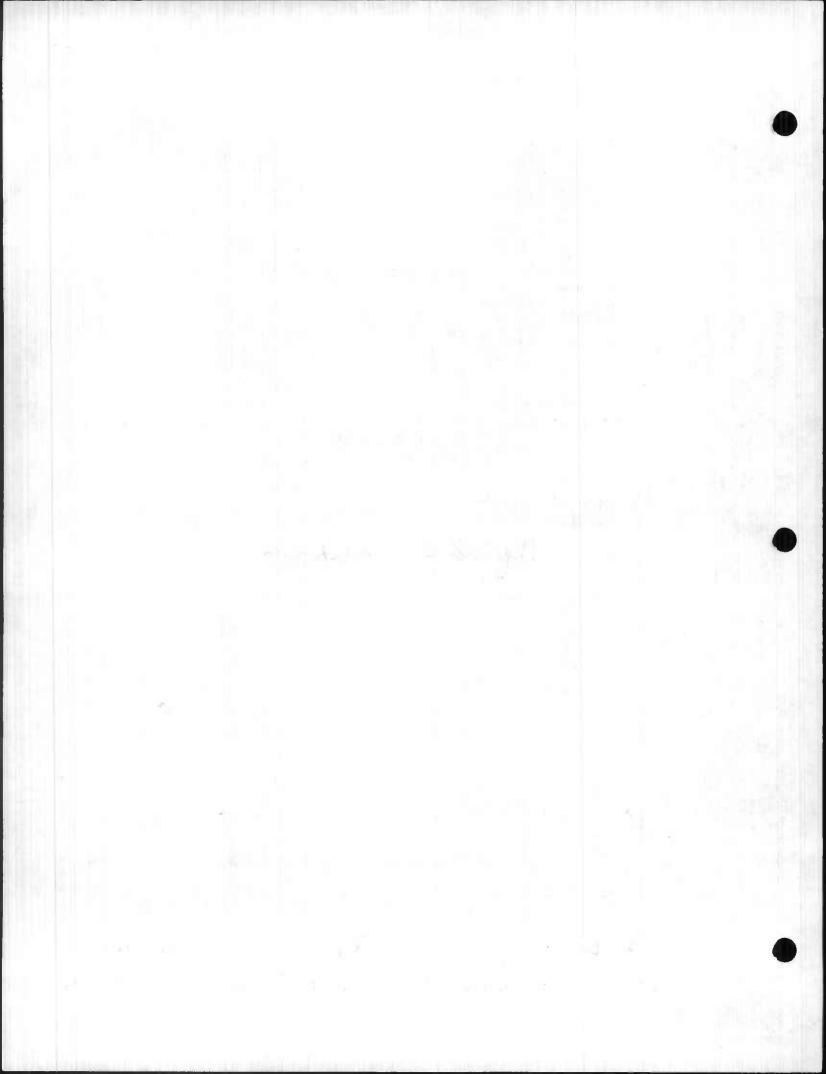
1 Yes 2 No If Yes, Give Year or Dates: 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours effer of Hygiena. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specity: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Heelth and Mentel Hygler Important: if Itam 27 is marked other th eny Injury or other traumatic event, the page. Cashier 12th Grade Food Store 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be William G. Parr Corabell Cheshire 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Brierwood Ct., Joppa, MD Mr. Edward H. Drane (husband) 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State Union Chapel Cemetery 4/14/00 Joppa, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. 21236 MD Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel ASCUI disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 987 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? been si 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificata Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this centilica B 25. Was case referred to medicat 26. Place of Deeth (Check only one) Hospital: 1 Inpetient 2 INER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1∏Yes 2□ No 10 After this 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 5 Pending 1 Natural
2 Accident 1 Yes 2 No investigation 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified APAL 10 2000 OME OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BULAND BULAN MO 21014 H10 879 6564 rabity m.o 728 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 ooks Registrar



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State of Manyland / Department of Health and Mental Hygiene o

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To Be Completed		15. Decedent's Education (Specify only highest grade completed)					16a. Decedent's Usual Occupation (Give kind of work done during most of working					1	16b. Kind of Bu	usiness/Indu	stry	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day 00 Javis 04 -ordelia 07 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Balt More

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
9-10-1947 Maryland Hosp.

jex Jr. Age (In yrs. last birthday)

M XXI F 52 Yrs. Baltimore of University If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1□M XXF Months Days 216-50-1461 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 3702 Parkfield Road USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Data Processing Unit College (1-4or 5+)
2 Veans Elementary/Secondary (0-12) 12th grade years Supervisor 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surneme) Levi Saunders Arneeta Harris 19a. tnformant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Pikesville, Md Rosetta Davis - Daughter 3702 Parkfield Road 20a. Method of Disposition

10 Burial 2 □ Cremation 3 □ Removel from State 20b. Place of Disposition (Name of cematary, cremetory or other place) 20c. Location - City or Town, State Loudon Park Cemetery 4-13-00 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Avenue 21215 Approximata Interval Between Onset and Death Baltimore, Md 23a. Part. Enter the decess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shum. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Sepsis Due to (or as a consequence of) rtora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Bowe hemic that initiated eventa resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 22 No 1 ☐ Yes 28 No 1 Yas 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 28i. Location (Street end Number or Rurel Route Number, City or Town, Steta) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

ision of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of Heelih and Mental Hyglene.
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permit. Pages Department of Important: If Its any injury or o

**Physician** 

/Medical

Examiner

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Certification: To

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29a. Certifier (Check only stee) Medical Medical Steel Signature and pitte of control of the con

page 2

Baitimore, Maryland 21215-0020

To the Hospital or Attending Physical P

State Registrar

**DHMH 16 Rev 6/95** 

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32. Registrare Signatura

ersor who completed cause of death (Item 23a) (Type, Print)

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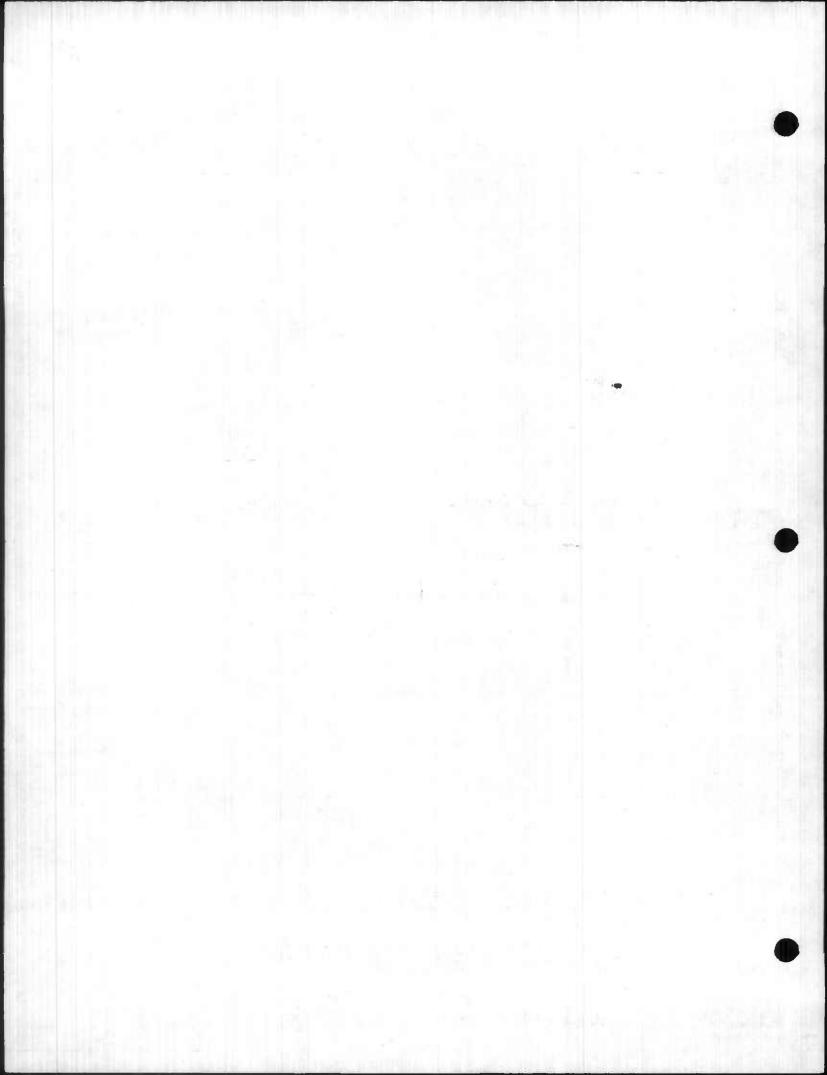
29d. Date signed (Month, Day, Year)

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Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death door 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) BALTIMORE AGNES HEALTHCARE If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign Country) Days -32-9638 Hours 10 M 20 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (ONo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SOCIAL Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last). 18. Mother's Name (First, Middle, Maiden Sumeme) IRBINIA Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of FURNIAL Service Licensee 22. Name and Address of Facility Do not enter the mode of dying, such as cardiac or respiratory arrest, Catorsulle 23a. Part 1. Enfer the disease, or complications that caused the death. shock, or heart failure. List only one ceuse on each line. Approximete tnterval Between Onset and Death Immediate Cause (Final etto USIOn Oleural disease or condition resulting in deeth) Dilatera Pheumonia 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 1 Yee 2 No tra hroni 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Yes 1 Yes 2□No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Ruret Route Number. City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. for use Records, P.O.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Funeral

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should be filed within 72 hours after on Mental Hygiene.

Pages 1 and 2 should be nent of Health and Mental

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**Physician** /Medical

Examiner

Examiner

Completed by Physician/Medical

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Baltimore, Maryland 21215-0020

or Attending Physician: Delehe/ Medical Certification: To hours efter death. within 24 hours To the Funeral

(Check only one) 29b. Signature and title of certific An E RecD
31. Date filed (Month, Day, Year)

29a. Certifier

M

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St.

eatth Care - 900 Caton Avenue Baltimore MD

APR 12 ZUUU St. Agnes
32. Registrer's Signeture

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Amended Item#19a perFHG782 4/12/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** FUANS WILLARD JAMES 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b, Gity, Town, or Location of Death 4c. County of Death Examiner Himonel HOPKINS on a If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 100M 20 F 257-66-2590 Georgia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or from 23s or 28s-f short the Medical Examiner must be notified at Da 1 Yes 2 □ No Funeral Director Himore NI 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2414 21213 MO O 12. Was Decedent Ever in U.S. Armed Forces? 14. Race -American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Nem 27 is marked other than "natural", or Nem any injury or other treumatic event, the Medical Examman Black, White, etc. 1 Never Married 2 Married 1 SYes 2 No 1□ Yes 2□No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Employed Mechanic 1141 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Evans Pottege readore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21213 Ima EVENS 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3 Removel from State 1 Buriet 2 Gremetion Bellinare 4 □ Donation 5 □ Other (Spec 4-11-2008 remetory 21. Signature of Fugeral Service License 22 Name and Address of Facility 1639 N. Broadwas Jeff miller 23a. Part I. Philer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PANCREATIC CANCER 8 MONTHS disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): physician s the buriel Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FAILURE by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Certification: To Be Completed GASTROINTESTINAL BLEEN 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠Inpatient 2□ ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1) S Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760. P.O. of Vital Records. Division or Attending Show

death with

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

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After

24 hours after death.

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filled in by

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4 Homicide

(Check only one)

29b. Signature and title of cartifier

29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) APR 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Top

NUTAKOR, 600 NORTH WOLFE 32. Registrar's Signature

MEDICAL DOCTOR

STREET, BALTIMORE, MARYLAND oaks

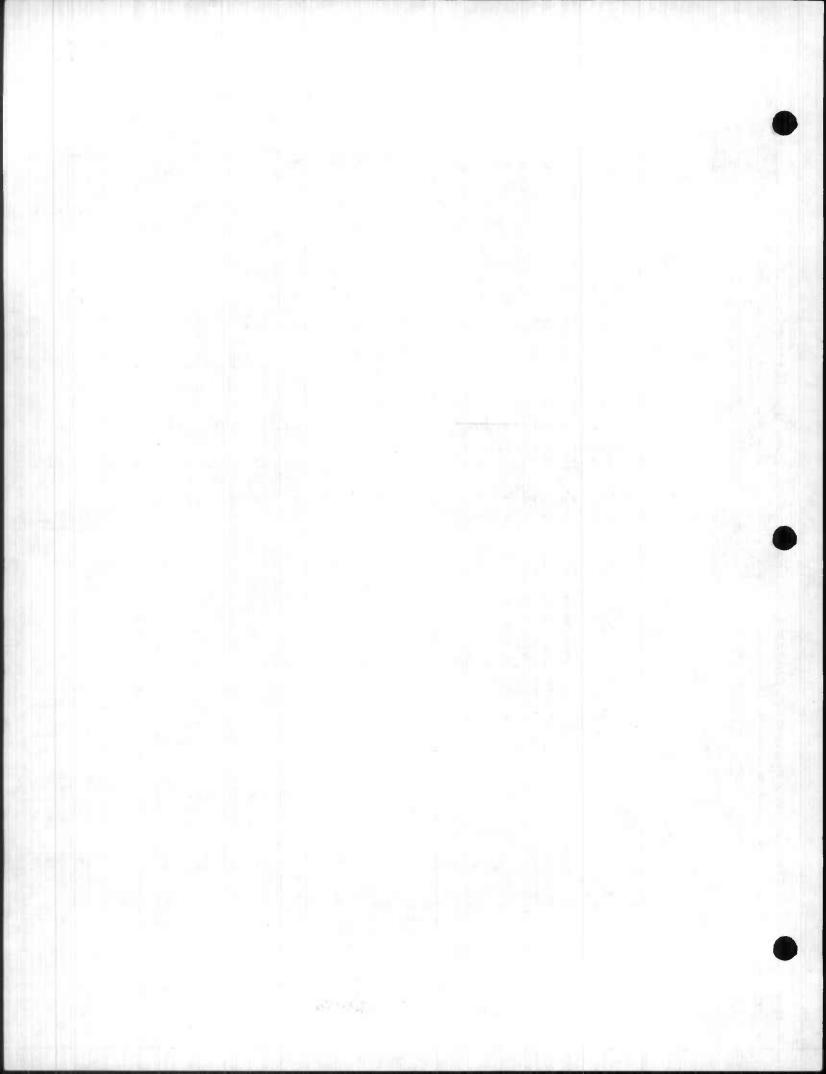
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

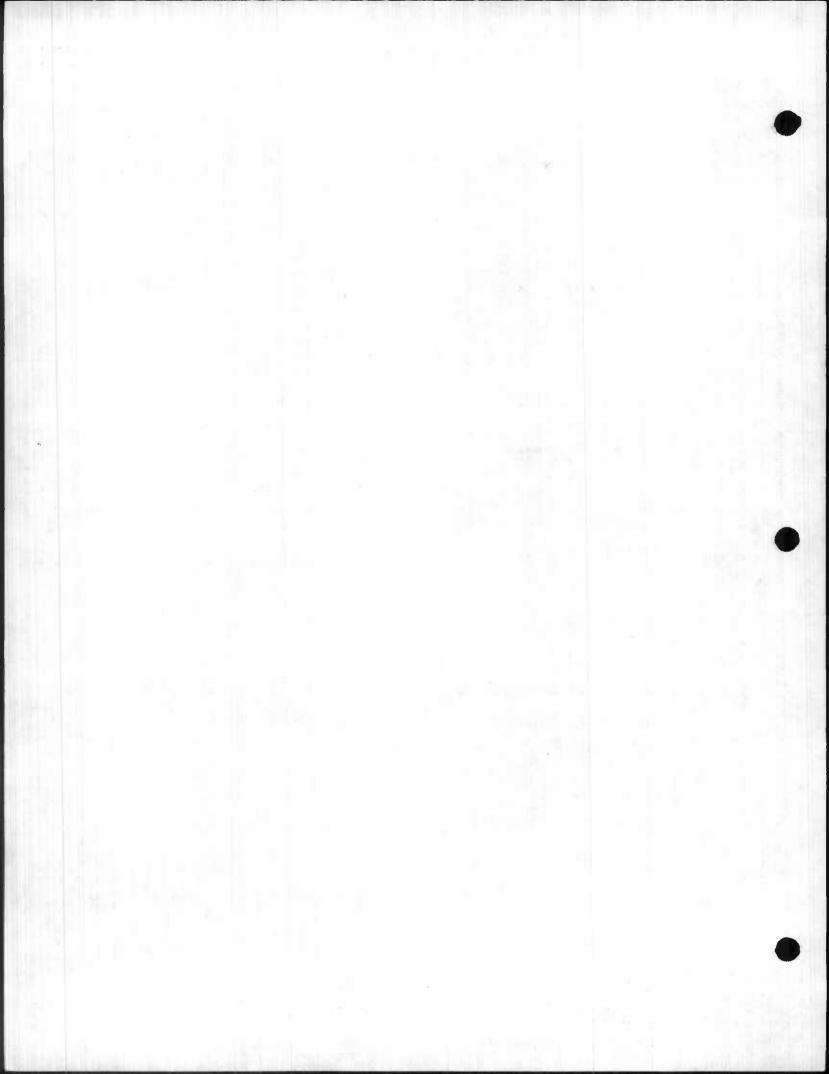
2000



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Physician Elwood Ellis 10, Henry 11:30 am April 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1529 Leslie Rd. Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months M 2 F Hours 461-28-6061 78 Director 30,1921 Texas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits mant be notified at 1 ☐ Yes 2 No Director Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1529 Leslie Rd. 21222 USA Norma 23a Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ★Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11 Merital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Hasilth and Mentai Hygiena. Important: if frem 27 is marked other than "natural", or herr any injury or other traumatic event, the Medical Expenses. Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12yrs. 2yrs. Industrial Engineer Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be James A. Ellis Elizabeth N. Nunley 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1529 Leslie Rd. Dundalk, Doloris Ellis wife Md. 21222 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Apr.12 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) Metro Crematory 2000 Catonsville 21. Signature of Funerel Service Licenses 22. Neme end Address of Fecility Connelly Funeral Home of Dundalk, P.A. 23a. Part 1. Enter the disease, or complications thet caused the death of not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Md. 21222 Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sougnous Examiner Examiner physician and the buriei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequenca of) Box 68760, Physician/Medical Due to (or es e consequenca of): 88 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by to d be detach 1 | Yee 2 | No 3 Probably 4 ☐ Unknown ò 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Was en eutopsy performed? Completed Deed paga 2 s 2 No certificata 1 ☐ Yes 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2U No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 hours after death.

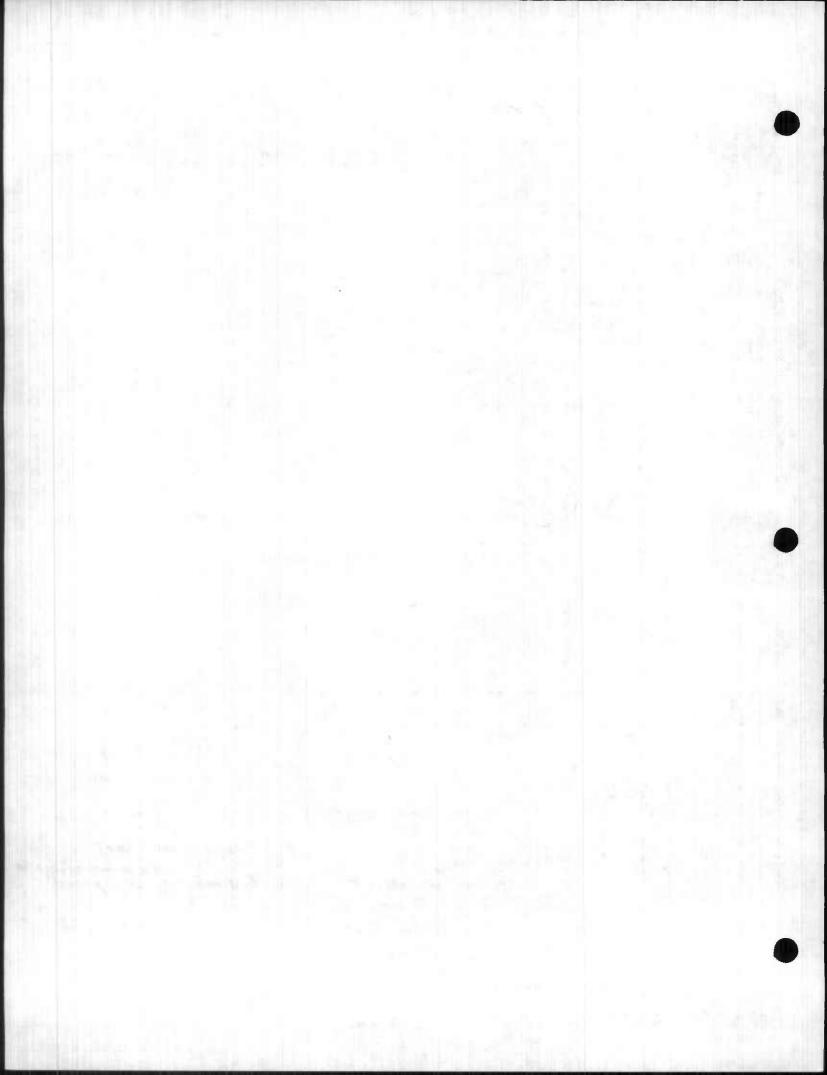
\*uneral Director: After this ely filled in by the funaral d 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury et Work? or Attending 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 4 ☐ Homicide edical 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar



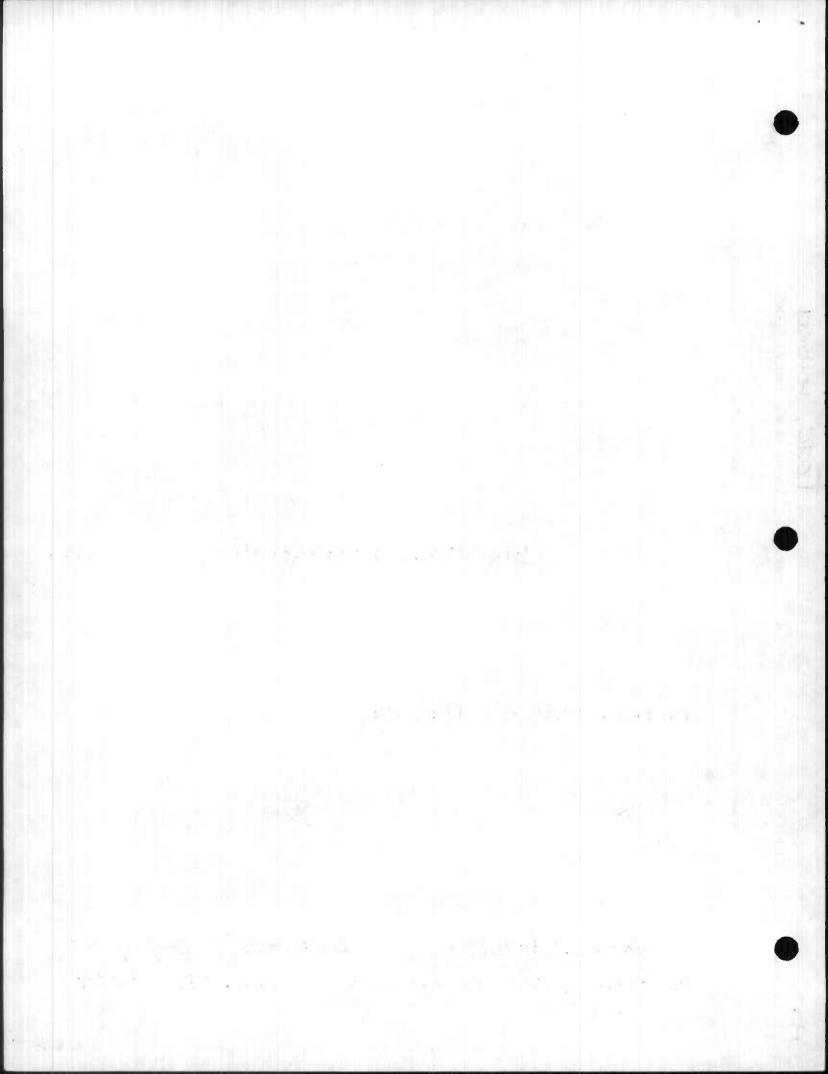
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State of Maryland / Department of Health and Mental Hygiene 00 | 1872.

			Ce	ertificate	of Dea	th	F	Reg. No.			
الالحجالا	1. Decedent's Name (First, Middle, Li	2. Date of Dea	ith	Year	3. Time of Death						
Physician /Medical	Alef Craig	Edmonds					APRIL	07 2	2000	10:10 P.M.	
Examiner	4e Facility Name (If not institution, gi				4b. City	, Town, or L	ocation of Death			120.20 2 4114	
	2700 BLOCK OF GREENMOUNT AVENUE BALTIMO							RE NA			
Funeral Director	218-19-2583	33 ODM 2 F 26 Yrs. Months Days Hours Mir					8. Date of Birth (Month, De) 12-1	Birth 9. Birthplace (State or For Country) MD			
pu .	Usuel Rasidence of Decedent  10a. State 10b. County 10c. City, Town or Location							10d. Inside City Lin			
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ar death with the Maryla there 23a or 28a-f ahon ner mark be notified at 'uneral Director	1706 Lakeside		10f. Zip Co 212	18			10g. Citizen of What Country? USA				
Dy F	11. Merital Status  1. Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Everamed Forces?  1 Yes 2 No If Yes, Give Yeer or Dates:	er in U,S. 13.	Was Deceden If Yes, specify 1☐ Yes 2√	c Origin? (Sp xican, Puerto ecity:	pecify Yes or No- Pican, etc.)	ecity Yes or No- Rican, etc.)  14. Raca - American Indian, Black, White, etc.  Specify: Black				
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0 -755	20a. Method of Disposition		20b. Place of Disp	osition (Neme	of r place)	1	Date	20c. Location	City or T	own, State	
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Physician /Medical Examiner	23. Fant. Enter the disease of shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Multip	e deeth. Do not e	nter the mode o	f dying, suc	h as cardiac			Ave	Approximete Interval Between Onset and Deeth	
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VICIAN: T Iclan: T Certifical rector, p	25. Was casa raferred to medical examinar?				26. 1	Place of Dea	th (Check only o	ne)			
Physic at this call direction To I	XX Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatio	ent 3 DOA	Other: 4[	☐ Nursing H	ome 5 Resid	lence 6XXXtt	ner (Speci	(h) SCENE	
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DIVISION OF DIVISION OF a flor death. af Director: After this led in by the tuneral of Certification: To	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide datarminad	28a. Plece of Injury building, etc.	- At home, farm, s (Specify)	treet, fectory, o	ffica		281. Location (S City or Tov	on, State) 400	BIT I	vnitridge Au	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification.	29a. Certifier 1 Certifying Pi (Check only one) Medical Exa	nyelcian: To the best of eminer: On the besis of ement manner stete	ny knowledge, dea camination end/or i	th occurred et investigation, in	he time, da my opinion	te and pleca , death occu	, end due to the rred et the tima,	cause(s) and m	annar as	stated. to the cause(s)	
To the within To the comp	29b. Signeture end title of certifier	1 11	1-	29c. L	icense num			29d. Date signe			
and b	30. Name and address of person who	completed cause of dea	th (Item 23d) (Type	Print)	O.C.	M.E.		APRIL 8	, 20	00	
The		adentz,	11		Stree	t, Ba	ltimore,	Maryla	ind 2	1201	
State Registrar	APR 1 2 2000	Senera	-	borks							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Physician P /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Localion of Deeth 4c. County of Death Examiner 8. Data of Birth (Month, Day, Year) If Under 1 Year 7. Aga (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** 180M 2□ F Months Days Hours Director ) Kic Usual Residence of Decedent 10a. Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits Olimore PKVII 1 ☐ Yas 2 No Director or 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s 21234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Stalus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filled within 1 ment of Health and Mental Hygiene. ant: If them 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy nginoering 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) To Be unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 31 vd #2206 mportant: If Item 27 ny injury or other tr altimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, Stata Data April 6 partment of 2 Cremation 3 Removel Irom State 1 D Burial 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Nama and Addrass of Facility E vans 21. Signature of Funeral/Service Licensi 23a: Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Deeth Physician /Medical Immediete Causa (Final diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attanding Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown sete has been signed by page 2 should be detact 1 ☐ Yee 2 ☐ No Records, Be Completed by 24b. Were autopsy findings avsilabla prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No certificete Division of Vital funerel director. 25. Was case refarred to medical 26. Place of Deeth (Check only ona) examiner? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mennar of Death 1 De Natural 28a. Data of Injury (Month, Day Year) 28b Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 ☐ Pending investigation deeth. 1 TYas 2 No 2 Accident 24 hours after deet Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 13 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier completely within 2 ş 29d. Data signed (Month, Day, Year) 2564 0000 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Baltmane Blud Walther 31. Data filed (Month, Day, Year) 32. Registrar's Signature State 2 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Foster 6, 2000 April 7:00 PM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Brooklyn Park Anne Arundel If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthdev) Birthplace (State or Foreign Country) Days Months 1□ M 2□ F 240-03-1953 82 JUNE 28, 1917 North Carolina Usual Residence of Decedent 10a, State 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Baltimore Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3819 8th Street B 21225 USA 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No 1 Never Married Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Oscar Little (Unknown) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roland Foster - husband 3819 8th St. B, Baltimore, Md. 21225 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 4/11/00 Pompano Beach, FL 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State Forest Lawn Cemetery, N. 4 □ Donation 5 □ Other (Specify) 22. Nama and Address of Facility 21 Signature of Funeral Service Licenses Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md.

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. 21075 Immediate Ceuse (Final hour disease or condition resulting in death) poremia Due to (or as a consequence of) Cordiomyo pathu schemic Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last Due to (or as a consequenca of) 1 month Neart ongestive Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3M Probably 4 □ Unknown Transitional Cell Cancer 24b. Ware autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy GASKO intestinal bleeding 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Dio 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending investigation 1 Yes 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Lal or Attending Physician: Tres efter deeth.

In Director: After this certificate ed in by the funeral director, pa

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

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**Funeral** 

Director

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72 hours efter death with the Manyland

Maryland 21215-0020

Baltimore,

Pages 1 end 2 should be nent of Health end Mental

-00 27

other

If item

permit. Page Department of Important: If any Injury or pace.

**Physician** /Medical

Examiner

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signed by the a

is certificate has b director, page 2 s

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

30. Name and add

29b. Signature and title of certifier

4 6 00

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

State Registrar Dogw/40 Road 32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD

Sinte 100

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

29c. License number

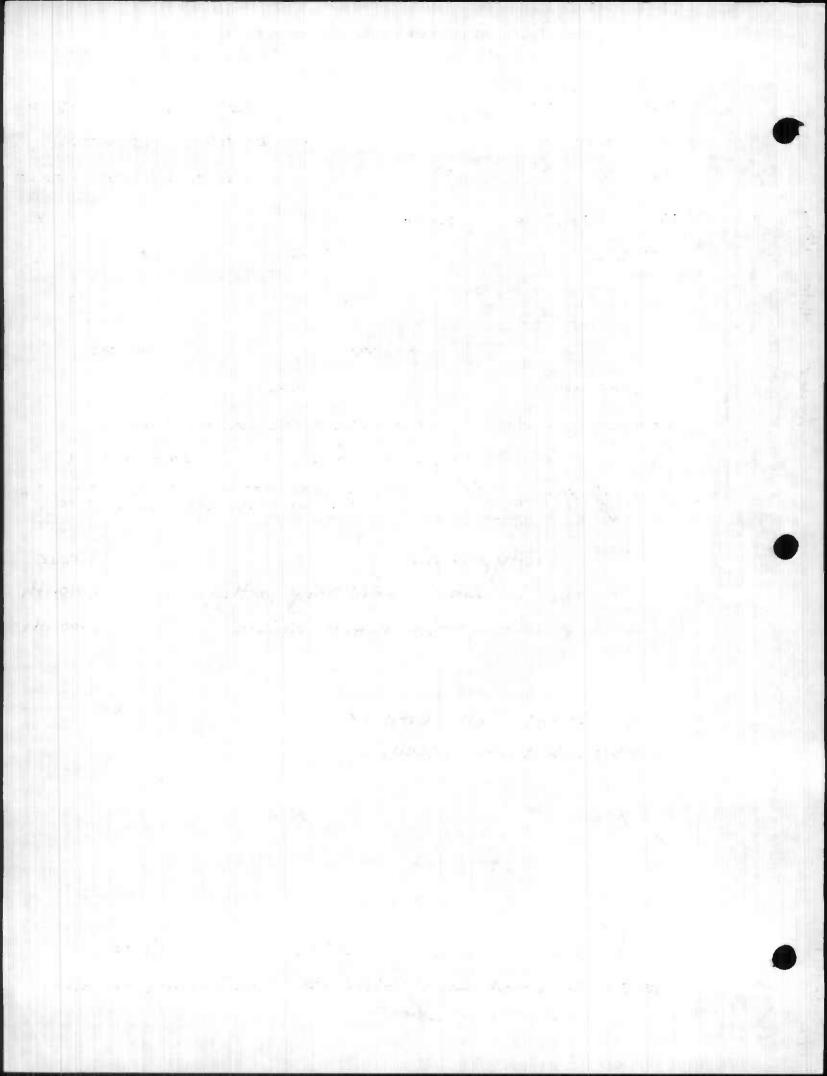
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29d. Date signed (Month, Dey, Year)

00

Glen Burnie, MD 21061

31. Date filed (Month, Dey, Yeer) APR 1 2 2000



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month DRi 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Samarita 5. Sociel Security Number Birthplece (State or Foreign Country) 6. Sex 7. Alge (In yrs. last birthdey) 100M 20 F 213-03 -2658 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 Yas 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) aco 14. Raca -12. Wes Decedent Ever in U,S. Armed Forcas? American Indian, 11. Merital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 Merried 1□ Yes 20 No Specify mite 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Man 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City of Jawn, State, Zip Code) 0 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece Date 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removef from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cence 22. Neme end Address of Fecility 21. Signature of Funerel Service Licenses Evans Funeral 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death INFARCTION Immediate Cause (Finel disease or condition rasulting in deeth) STENOSIS- 4eg SUBAORTIC Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lest ATTGOVENTY CUCAR Due to for DISEASE ocar ( 23b. Did tobacco use contribute to the cause of death' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HRONIC 1 Tyes 25. Was case referred to medical axeminer? 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3D DOA 27 Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated.

2 No

Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

or Attending after death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show ment be notified at

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items 23s

Department of Heelth and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic svent, the Medical Exemples.

**Physician** 

/Medical

Examiner

physician and the burial-trans

Examiner

Completed by Physician/Medical

To Be

Certification:

edical

1 Waturel

2 Accidant

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signeture and title of certifie

30. Name and address of person 0 31. Dete filed (Month, Dey, Year)

5 Pending investigation

6 Could not be

2

APR 1

2000

this

After

Director:

within 24 hours at To the Funeral D To the Hospital

filled in by

Baltimore, Maryland 21215-0020

death

Director

Funeral

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Completed

Be

Division of Vital Records, P.O. Box 68760,

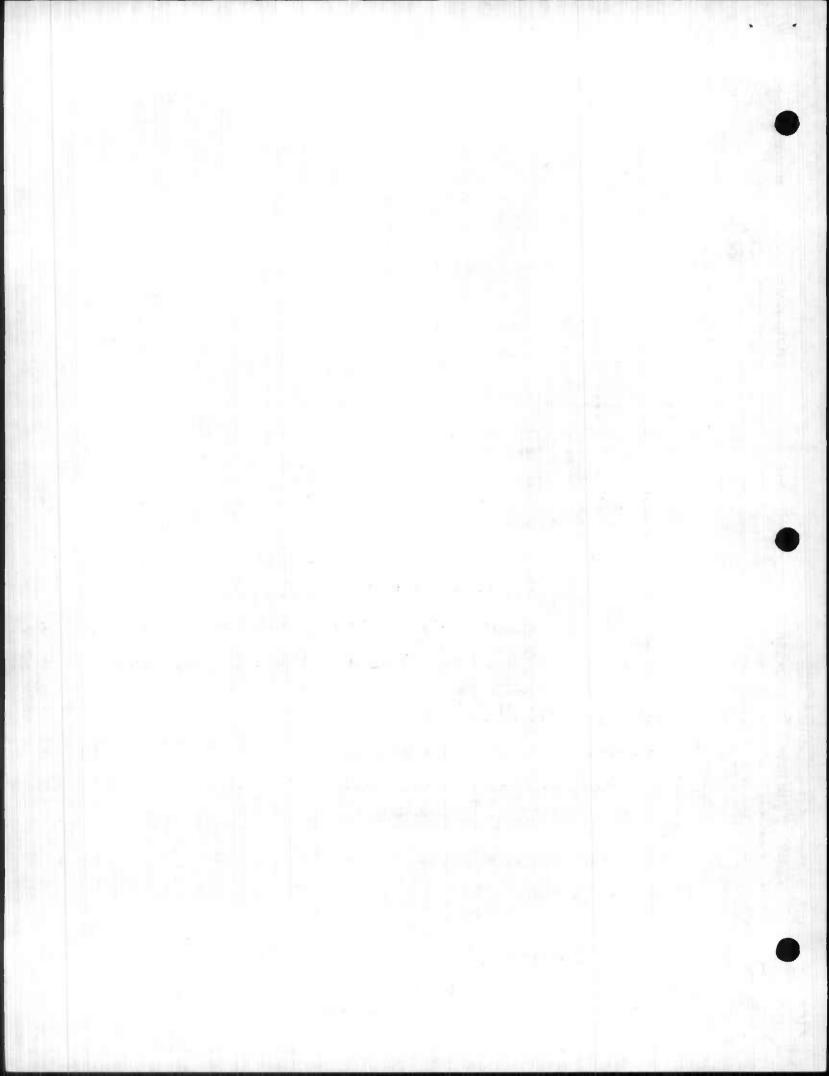
State Registrar

DHMH 16 Rev 6/95

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signetura

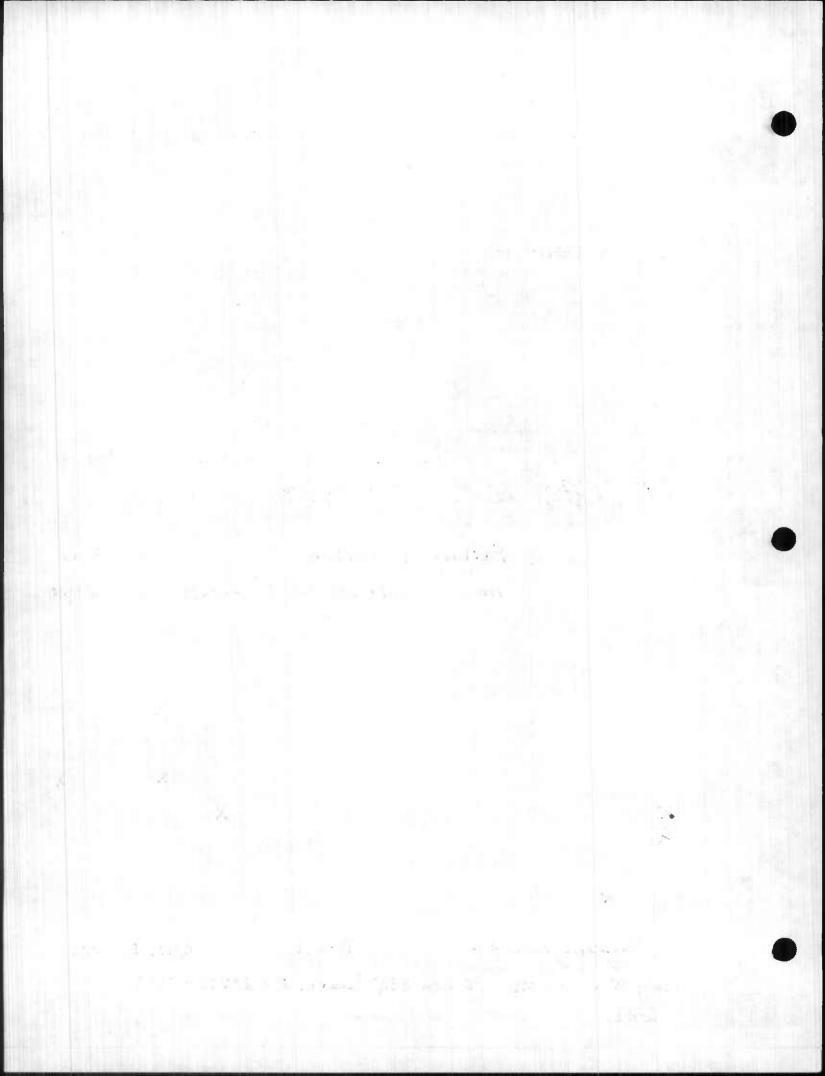


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State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death Reg. No.											
	1. Decedent's Neme (First, Middle,						Date of Deeth 3. Tima Month Day Year					
sician edical	Bradley Thomas			Apri					5:08PM			
iner	4a Facility Name (If not institution, 9579 Donnan Ca	give street and nu stle Cou	im <i>ber)</i> rt			4b. City, Town, or Loc West Laur				eath 4c. County of Deeth Howard		
	5. Sociel Security Number 212-64-4546	last birthdey)	Months Days Hours Min.			Min,				place (State or For		
	Usual Residence of Decedent		33						April 1	0, 1900	па	waii
	10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	IOd. Inside City Lin
Director	MD Howar	d	W	lest La	t Laurel				100 Citimen of What Co			1 ☐ Yes 2 ☐
	10e. Street and Number 9579 Donnan Ca	stle Cou	rt		10f. Zip Code 20723					10g. Citizen of What Coun		
Completed by Funeral Director	11. Marital Status	12. Wes Dec	edent Ever in U	J,S. 13.	Was Deced	lent of H	ispanic Ori	nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.) 14. Race - American Ind Bleck, White, etc.				
	Never Merried 2 Marrie  3 Widowed 4 Divorced		ZONo ive		1 ☐ Yes 2 ☐ No Sa				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify: White		
	15. Decedent's (Specify only highest			(Give	dent's Usua kind of wor	k done	durina mos	t of worki	ing	16b. Kind of Bu	isiness/in	dustry
	Elementary/Secondary (0-12)	College (	1-4or 5+)		life. DO NOT use retired)							
	17. Fether's Neme (First, Middle, L	2		Bill	Billing Clerk			e Alomo	/Eiset Middle	Bever		
8					18. Mother's Neme (First, A					Maioen Surrain	10)	
9	David H. Girar					Marsha Taylor						
	19a Intorment's Name/Relationsh Marsha Girard	p (Type, Print)								r, City or Town, land 20		Code)
	20a. Method of Disposition 1 Burial 2 X Cremetion	B □Removel trom	Stete	20b. Place of Disposition (Neme of					Date	20c. Location -		
	4 □ Donation 5 □ Other (Sp.	ecify)	Bal	lt. Was	sh. C	rema	atory	04	4/05/00	Laurel,	, Maryland	
n/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Failure to Thrive  Due to (or as a consequence of):  Amystrophic Lateral Sclerosis  Due to (or as a consequence of):  Due to (or as a consequence of):										10 yrs	
Physician	Part II. Other algnificant condition	e contributing to d	onth but not m	euiting In the u	nderhvina ca	auco cir	on in Part I		COL Didahara and Adhara and A			a the cause of de
	Parti. Other arginicant condition	s contributing to d	eath but not re:	suling in the u	moenying ca	ause giv	en in Fari			23b. Did tobacco use contribute to the cause of the cause		
Completed by										an autopsy med?	av	ere eutopsy tindin railable prior to empletion of cause death?
OT									1 D	es 2 No	11	Yas 2 No
Be	25. Was case reterred to medical						26. Place	ot Death	n (Check only o	ne)		
To	examiner? Ves 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Oth	ier: 4 Nu	ursing Ho	me 5 Resid	enca 6 Oth	er (Speci	fy)
	27. Manner of Deeth  1 Netural 5 Pending 2 Accident investigs		of Injury oth, Day Year)	28b. Time of Injury	t 26	8c. Injui Wor				ow Injury occurr		
Certification:	3 Suicide 6 Could no determin	ad 200. Place	e of Injury - At h ing, etc. (Speci	nome, term, str	reet, fectory,	, offica			28f. Location (S City or Tow		er or Run	el Route Number,
edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the taminer: On the band man	best of my kno asis of examina aner stated.	owledge, deetl ation and/or in	h occurred a vestigetion,	at the tir in my o	ne, date an pinion, dea	d placa, i	and due to the o	cause(s) end ma date and placa, (	nner as s and due t	stated. o the ceuse(s)
Me	29b. Signature and title of certifier	4			29c.	. Licens	e number			29d. Date signed	d (Month,	Day, Year)
	Han 21	Imes 5	NO.			03	0111			April !	5 1	000
	20 Name and add 1	1	an of doubt to	- 02e\ T		US	-111			est. Las !	3/ 0	000
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ate trar	APR 1 2 2000	Sen	registrers Sign	D 1	boark	2						



Physician/Medical Examine signed by þ

25. Was casa rafarred to medical examinar?

XX Yes 2 No

27. Mannar of Death

1 Natural

2 Accident

4 Homicida

Completed

Be

edical Certification: To

page

After this

within 24 hours a
To the Funeral D To the Hospital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed?

Yes 2 No 24b. Wara autopsy findings available prior to completion of cause of death? Yes 2□ No

26. Placa of Death (Check bnly one) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify)

28d. Dascribe how injury occurred

SELF-INFLICTED

28f. Location (Street end Number of Rure House Number City or Town, Steta) ANTILITAN BATTLEFTELD. SHARPSBURG, MD

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and mannar as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

28c. Injury at Work?

1 Yas 2 No

April 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury Month, Dey FOUND:

4-6-00

LARON ocke 31. Data filed (Month, Dey, Year)

5 Pending invastigation

6 Could not be

111 Penn Street, Baltimore, Maryland 21201

State Registrar

APR 12 2000

32. Registrar's Signature Course

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P.O. I

Division of Vitai Records.

The law requires

Physician:

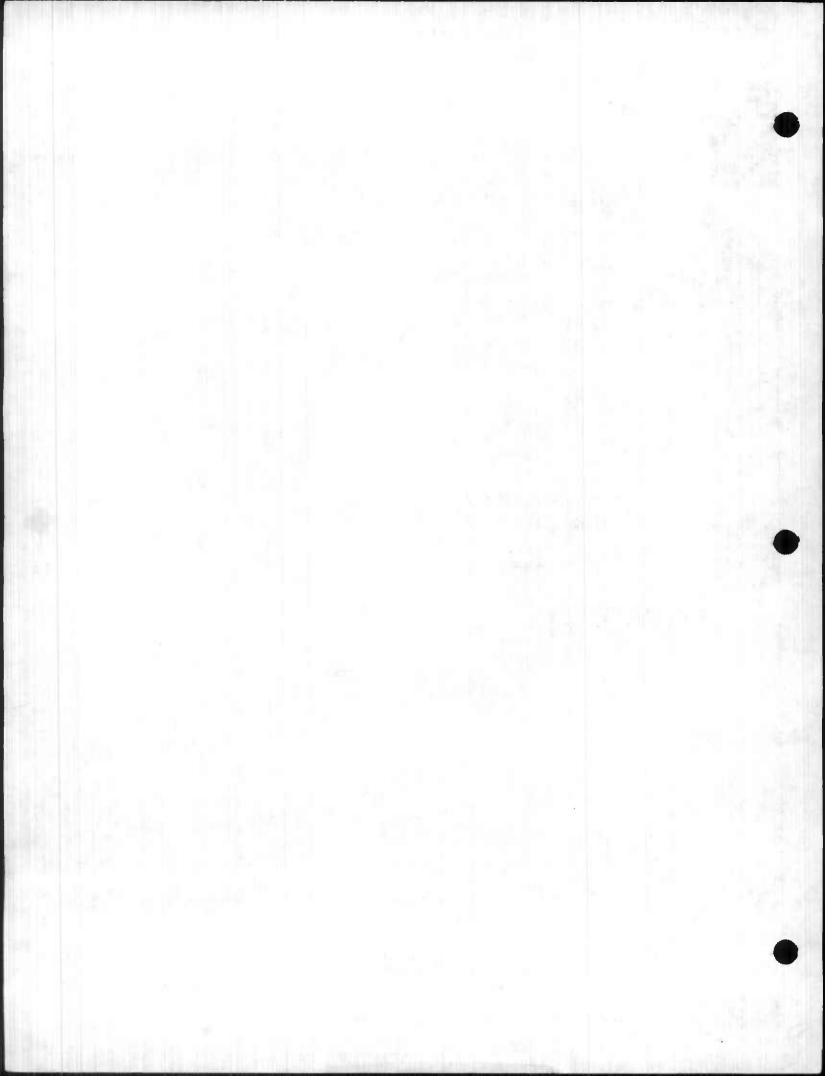
or Attending s after des. 2X ER/Outpatient 3□ DOA

28b. Time of

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

PICNIC AREA



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 5123 A.M 95 CD D 2000 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cen 129 05 ita er HIMORE 601 tar H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Months Days 10 M 20 F 219 16 7230 82 5/12/ MD. Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE 1 ☐Yes 2 ☐ No MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? #405 CONWAY ST. WEST 21201 USA 1 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 戶 No If Yes, Give Year or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. AFRO 1 Never Merried 2 Merried 1 Yes 24 No Specify: Specify: AMERICAN 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 0 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) ELI BOOTHE LAURA GREEN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) BARBARA VINES BALTO. MD. 4205 PASCAL AVE. 20b. Place of Disposition (Neme of cematary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta # Burial 2 ☐ Cremation 3 ☐ Removel from Stete ZION CEM 4/11/00 MAGOTHY, MD, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME PA . 1300 EUTAW PL BALTO. MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on aechiline. Approximata tntervel Between Onset end Death Immediate Cause (Final monar diseasa or condition resulting in death) DU Due to (or as e consequency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Disease ne a to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings eveilable prior to completion of cause of daath? 24e. Wes en eutopsy performed?

**Physician** /Medical Examiner

The law requires that the death certificata be axecuted

P.O. Box 68760,

Division of Vital Records,

**Physician** 

/Medical

Examiner

Director

Funeral

p

Completed

8

10

**Funeral** 

Director

r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notined at

permit. Pages 1 and 2 should be illed within 72 hours after death with the Department of Health and Mental Hygiene. Introcrement of Health and Mental Hygiene. Introcrement if item 27 is marked other than "natural", or frem 23a or 2 enty injury or other treumatic event, the Medical France.

Baltimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical à Completed Be

attending physician and for use as the buriel-transit been signed by the a should be detached certificate funeral director, Certification: To After s efter death. filled in by

Hospital or Attending Physicien: within 24 hours of To the Funeral D edical completely ŝ

this

State

Registrar

25. Wes case referred to medicat examine? 1€ Yes 2□ No 27. Menner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

29b. Signature and little of certifier

29a. Certifier

5 Pending investigation

6 Could not be detarmined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)

28c. tnjury et Work? 1 Yas 2 No

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28d. Dascribe how injury occurred

1 Yas

26. Place of Death (Check only one)

South

 Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

2 No

1 Yes 2 No

30. Name and address of person who compl d causa of eth (Item 23a) (Type, Print)

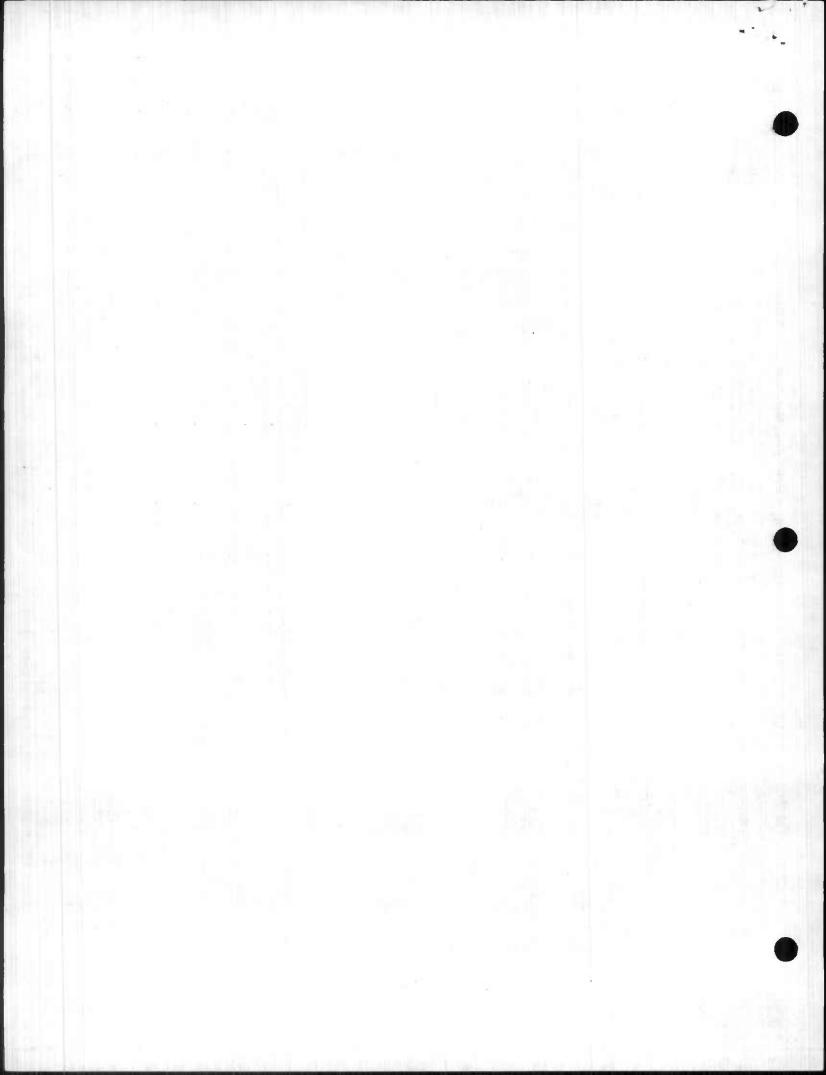
29c. License number

29d. Date signed (Month, Day, Year)

Hanover Street

0/1

31. Date filed (Month, Day, Year) 32. Registrar's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dev Physician GRACEY ANNA BELLE AGRIL 15=144 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HALFOND HOSPITAL FALLSTON FALLSTON GENERAL 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 220-22-2287 1□ M 2☑ F Hours Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford 280-1 Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Burlington Court V 21040 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ⊃ ⊃ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Ag 3€ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Years Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H is merked off William Parker Viola Anderson 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Ithem 27 I Mrs. Joyce F. Cochran (Daughter) P.O. Box 521 Forest Hill, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Date XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 4/14/2000 Middle River, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. 7922 Wise Ave. Dundalk, Maryland Approximete Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No of Vitai 25. Was case referred to medical examiner? 1 > Yes 2 No 26. Place of Deeth (Check only one) Medicai Certification: To Be Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 15 Inpatient 2 ER/Outpatient 3 DOA After this s after death. I Director: After this od in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28c. Injury at Work? Division or Attending 5 Pending investigation 1 DiNetural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DME

Registrar **DHMH 16 Rev 6/95** 

State

Annabell

rocey,

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

728 BULANN NO

32. Registrar's Signature

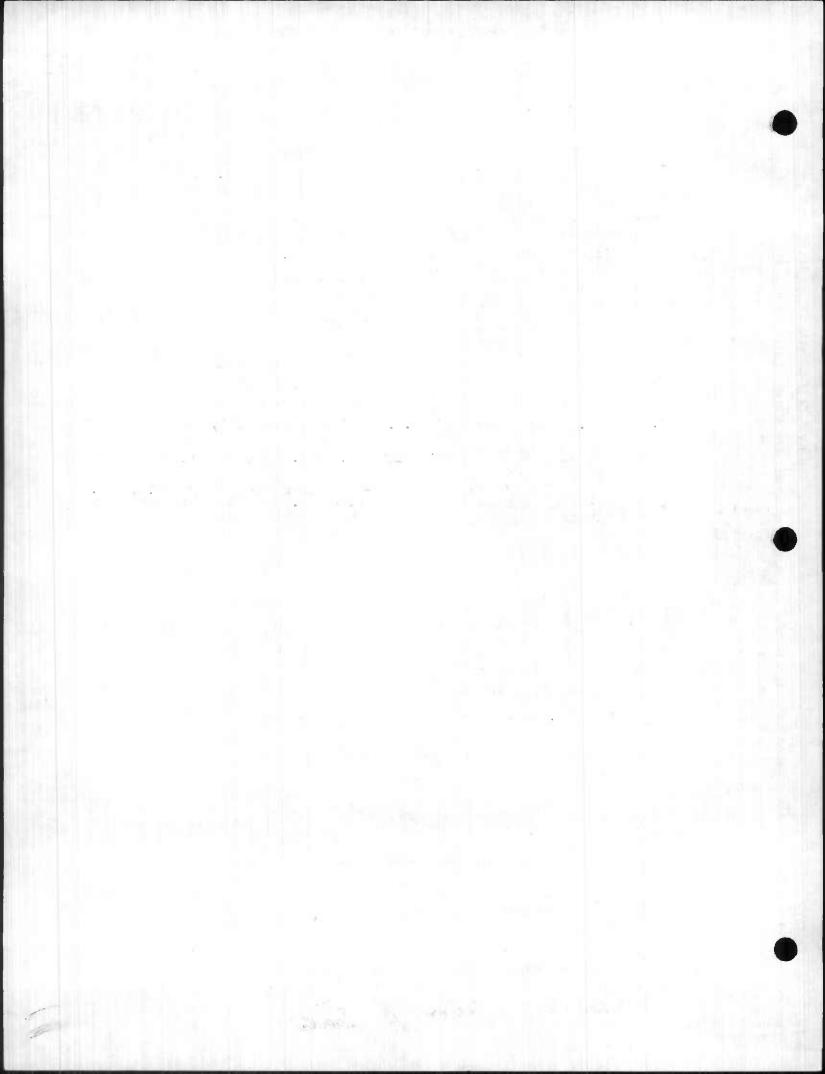
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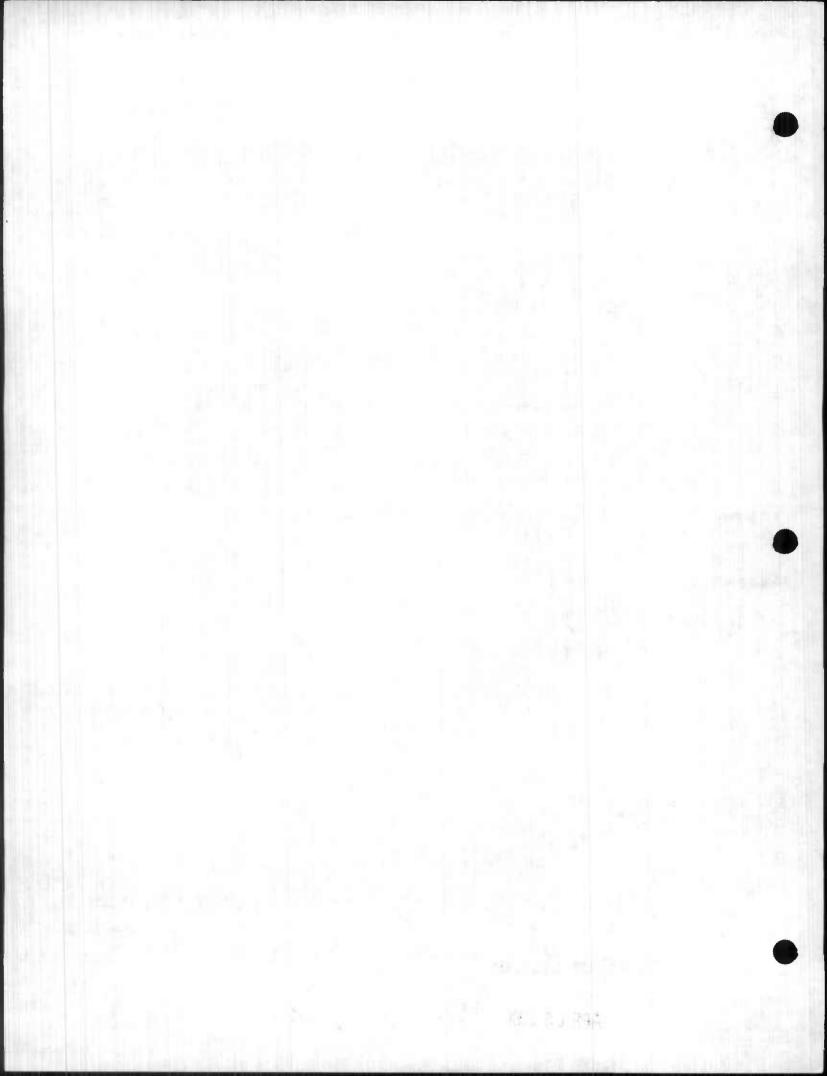


00-077 00-1956-510 Eric Donnell Ghee

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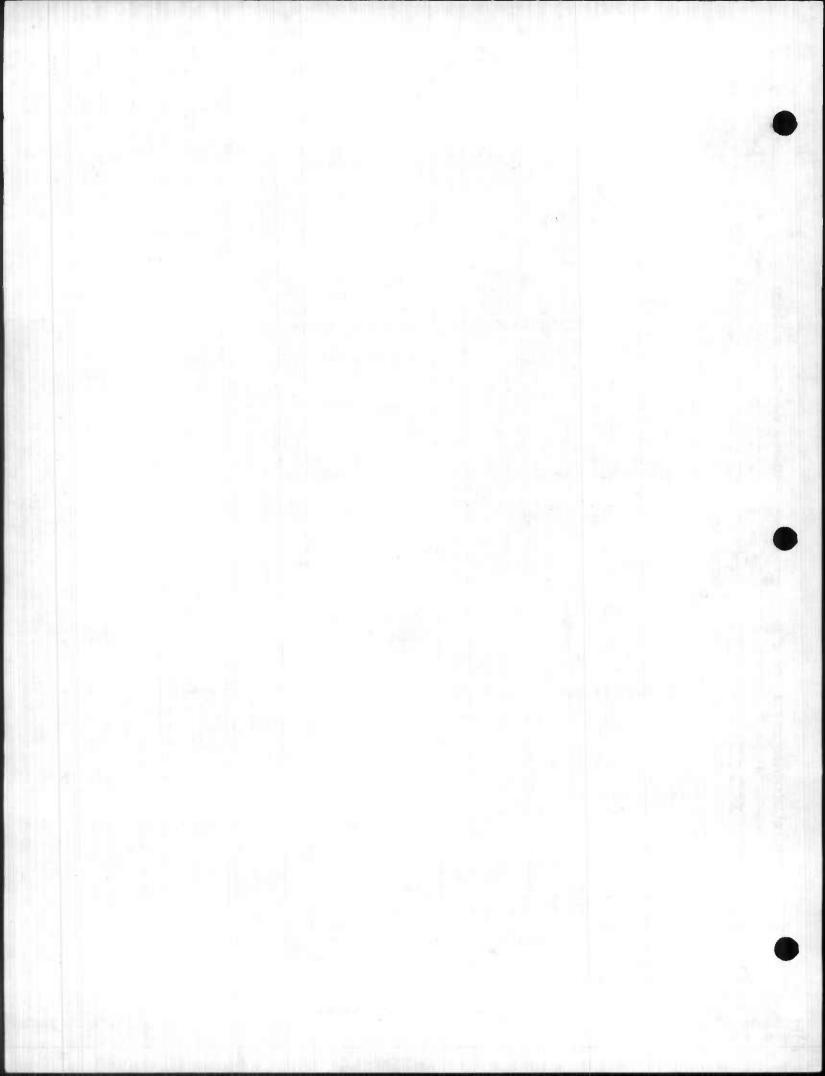
State of Maryland / Department of Health and Mental Hygiene 00 11880

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xaminer	48 Facility Name (If not institution, gi 117 N.EUTAW STRE					b. City, Tow BALTIN	n, or Location	n of Death	4c. County	of Death		
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Medical Examiner	Immediata Causa (Final disease or condition resulting in deeth)  Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseasa or Injury that Initiated events rasulting in death) Last	e	Dua to (or as a cor	sequance of):		00	Nove	land				
etached for use a	Part II. Other significant conditions	contributing to death t	out not resulting In th	a underlying cau	se give	en in Part I.		23b. Did toba	eco use co	ntribute to	the cause of de	
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Completed by								24e. Was an e perlorma	eutopsy d?	av co	ara autopsy findin eilabla prior to mplation of cause death?	
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tification: To Be	examiner? 1 XX Yas 2 □ No 27. Mannar of Death	28a. Data of Injury (Month, De	ary Year) 28b. Tim	2 M	101		281. 1	rbjec	# She	y	A Route Number,	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** HENRY 8:30 PM LOIS APRIL 11 2000 /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE BALTIMORE If Undar 1 Year | Months | Days If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F Mary land 214-30-6486 uno 18.1932 Director Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits altemor 1 ☐ Yes 2 No Director 280-1 94 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? b munt be 21234 Nerna 23a 100h Funeral 12. Was Decedent Evar in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 72 hours after 1 ☐ Yes 2 No 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 8 White Yes. Give À 3 Nidowed 4 □ Divorced Year or Dates: 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) nome marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nant of Health and Mental dawrence IONLES 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) . Villiam or other tra altimore APRIL 15 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removel from State Important: II any injury o pose. Moreland Mem □ Donetion 5 □ Other (Specify) 21. Signeture of Fuperal Service Licensee 22. Name end Addrass of Fecility UND Hemore, Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter the diseesa, or complications that caused the death. shock, or heart feilura. List only one causa on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel SEPTIC SHOCK disaese or condition resulting in deeth) DAYS Examiner Due to (or es a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. physician Physician/Medical the Due to (or es a consequence of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ZX No 3 Probably 4 Unknown signed t MYOCARDIAL ISCHEMIA Division of Vital Records. à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 2 X No 1 ☐ Yes 2 No or Attending Physician: 25. Was case refarred to medical axeminer? 89 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No death. Investigation 2 Accident after death 6 Could not be determined 3 Suicide 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours a 24 hours Funeral DE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

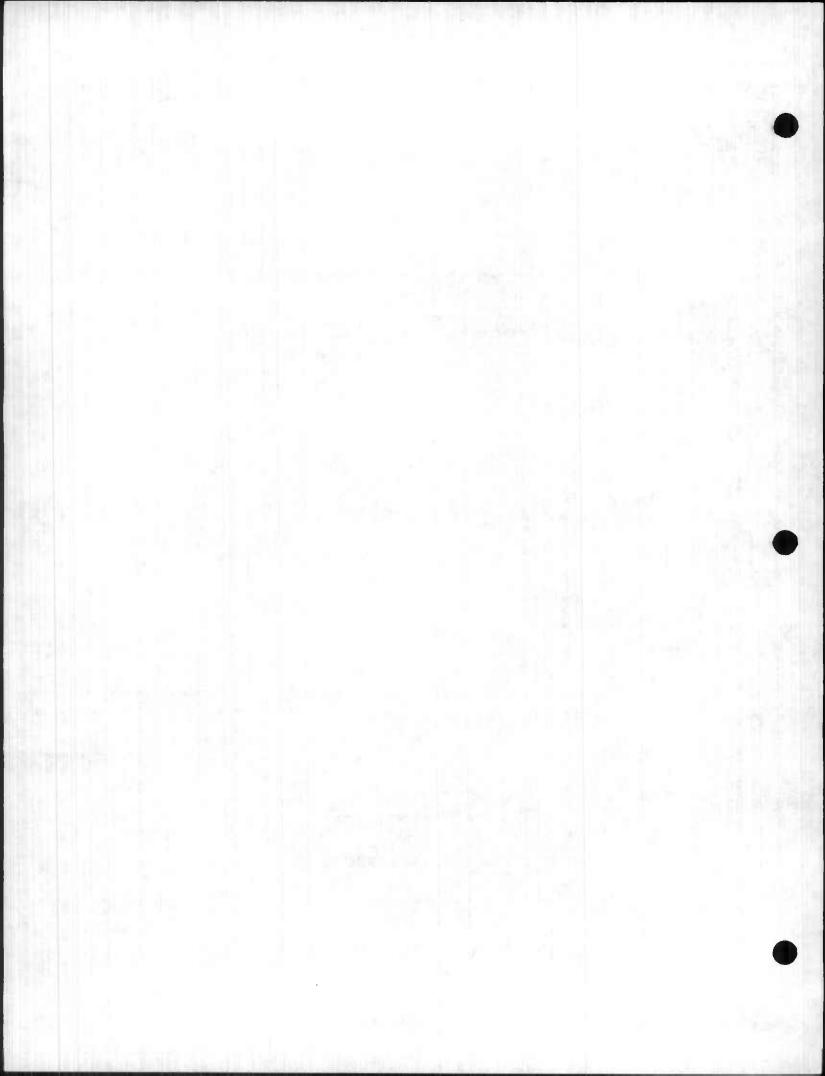
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signeture end title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) Bl MEDICINE RESIDENT APRIL P13449 11 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCHRAVEN BLVD. GOOD SAMARITAN HOSPITAL BHARTI ABICHANDANI, MD BALTIMORE, MD-21239 31. Date filed (Month, Day, Year) APR 1 2 32. Registrar's Signature State 2000 oaks Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 11882

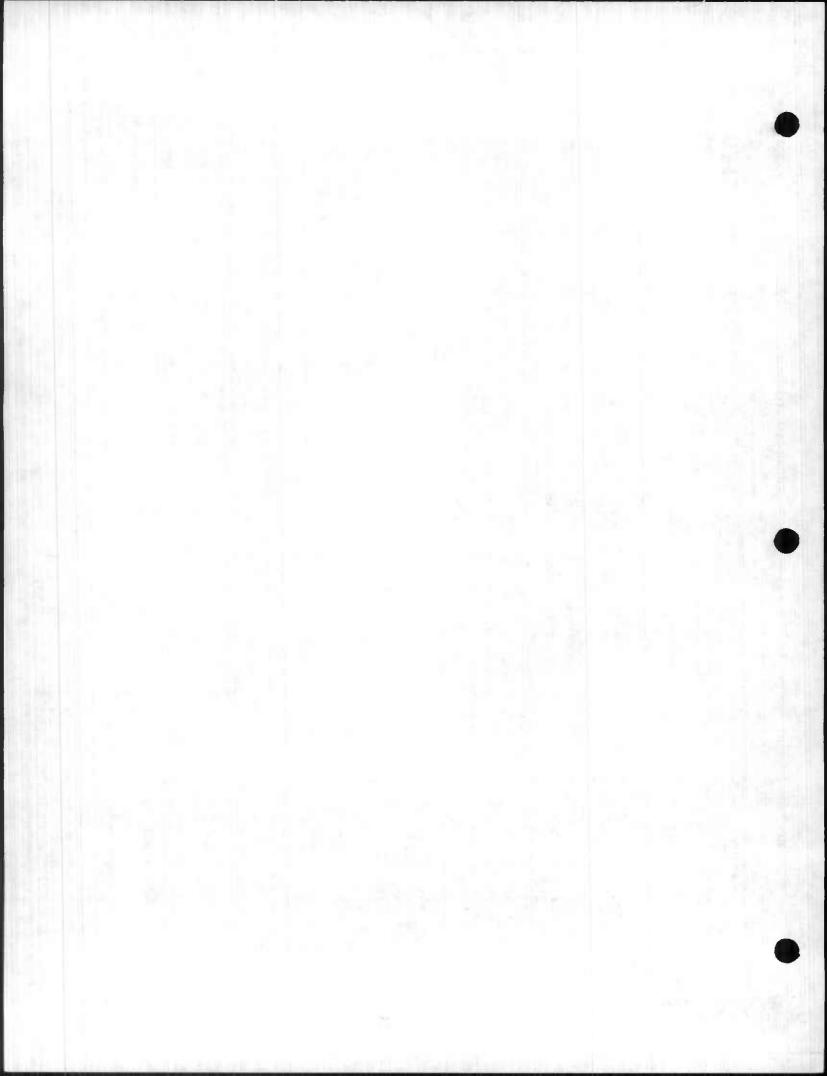
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17. Father's Name (First, Michae), Last)   18. Mother's Name (First, Modie, Name of Date)   19. Mailing Address (Street and Number or Rural Follows Name)   19. Mailing Address (Street and Number or Rural Routs Name)   19. Mailing Address (Street	ple			- (C	a. DO NOT use retir	red)	or working					
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Same   Specific   Same   Specific   Same   Specific   Same   Same   Specific   Same						18. Motha	r's Nama (First, I	Middle, Maide	en Sumame)			
Betty M. Hall (Wife) 3809 Roland Avenue, Baltimore, Maryland 21211  20s. Method of Disposition (James of Commendation of Comme		James Frederick	Hall			Cat	herine l	Marie :	F1ynn			
20. Method of Disposition 1		19a. Informant's Name/Relationship	(Type, Print)	19b. N	lailing Address (Stree	et and Numbe	er or Rural Route	Number, City	or Town, S	tata, Zip	Code)	
A part   A		Betty M. Hall	(Wife)	38	09 Roland	Avenue	e, Balti	more,	Maryla	and :	21211	
Type   Committed		20a. Method of Disposition		Ob. Place of D	isposition (Name of							
21. Signature of Funeral Service Licensee    22. Name and Address of Facility Schaimmek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213							4/12	/00 Ba	ltimor	e. M	farvland	
Sale Part   Enter the disease or conflictions that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, approximate shock, or heart failure. List only one cause on each line.    Arteriosclerotic Cardiovascular Disease   Dua to (or as a consequence of):			**	Daleline	22. Name and Add	rass of Facilit	y			, .	- J	-
23e. Part. Enter the diseases or conditions are considered in that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast.    Approximate interval Batween Consett failure. List only one cause on each line.	8	I CHARATE	2	0.00								
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disease or condition rasulting in death)  But to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury intellated events rasulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury intellated events rasulting in death) Last  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Chronic Obstructive Pulmonary Disease  24a. Was an autopsy performed?  Chronic Obstructive Pulmonary Disease  25. Was case referred to medical examiner?  25. Was case referred to medical examiners and injury of the cause of death (Check only ona)  25. Was case referred to medical examiners and injury of the cause of death (Check only ona)  27. Manner of Death (Check only ona)  28. Date of Injury of I		immediata Cause (Final	Antonios	al ameti	a Cardian	2001	- Dices					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury M		disease or condition	a			asculai	r Diseas	е				_
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Cause (Disease or Injury Initiated events initiated events initiated events initiated events initiated events initiated events resulting in death) Last  Part It. Other elgnificant conditions contributing to death but not resulting in the underlying causa given in Part I.  Chronic Obstructive Pulmonary Disease  24a. Was an autopsy performed?  Inspection 1 Yes 2 No 1 Yes 2	xar	Sequentialty list conditions, if any, leading to immediate	Dua	to (or as a cor	nsequence of):							
Part It. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I.  Chronic Obstructive Pulmonary Disease    Chronic Obstructive Pulmonary Disease   24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of causa of death?   1   Yes 2   No   No   Yes 2   No   1   Yes 2   No   Yes   Y		Cause (Disease or Injury	C		W. Carlotte							
Part It. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part I.  Chronic Obstructive Pulmonary Disease  24a. Was an autopsy performed?  Inspection  1   Yes 2   No 3   Probably 4   Unknown of June 1   1   Yes 2   No 2   Yes   Ye	olbe	rasulting in death) Last	Dua	to (or as a cor	nsequence of):							
24a. Was an autopsy performed?  Inspection    1   Yes   2   No	M		d									
24a. Was an autopsy performed?  Inspection    1   Yes   2   No	cian						1 ==	b 01141		aller in a	Abo and a district	
24a. Was an autopsy performed?  Inspection 1   Yes 2   No   1   Yas 2   No    25. Was casa raferred to medical ayaminer? Yell Yes 2   No   No   No    26. Place of Death (Check only ona)  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA    Other: 4   Nursing Home 5   Residance 6   Other (Specify)  27. Manner of Death 1   Natural 5   Pending invastigation 3   Suicide 6   Could not be datermined    28a. Date of Injury   At home, farm, street, factory, office    28b. Linjury at Work?   1   Yas 2   No    28c. Injury at Work?   1   Yas 2   No    28d. Dascribe how injury occurred    28d. Location (Street and Number or Rural Routa Number, City or Town, State)	iysi	Part II. Other significant conditions	contributing to death but no	ot resulting in th	ne underlying causa (	givan in Part I	. 23					
24a. Was an autopsy performed?  Inspection 1   Yes 2   No   1   Yas 2   No    25. Was casa raferrad to medical axaminer? Yell Yes 2   No   No   No    26. Place of Death (Check only ona)  Other: 4   Nursing Home 5   Residence 6   Other (Specify)  27. Manner of Death   No   No   No   No   No   No    28. Date of Injury at   North Natural   S   Pending invastigation   North Natural   North Natural   S   Pending invastigation   North Natural   North Natural   S   Pending invastigation   North Natural		Chronic Obstruct	ive Pulmonar	y Dise	ase			1 U Yss	2∐ No 3	- Prob	HENRY 4 LAUNKNOWN	1
25. Was casa raferrad to medical axaminer?  Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Pacidanca   6   Other (Specify)    27. Manner of Death   1   Natural   5   Pending invastigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Routs Number, City or Town, State)    28. Place of Death (Check only ona)   Other:   4   Nursing Home   5   Pacidanca   6   Other (Specify)    28d. Dascribe how injury occurred   28d. Dascribe how injury occu	Q P						248	a. Was an au	topsy	24b. We	re autopsy findings	
25. Was casa raferrad to medical examiner?  Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residanca   6   Other (Specify)    27. Manner of Death   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residanca   6   Other (Specify)    28a. Date of Injury   28b. Tima of Injury   Month, Day Year   1   Yas   2   No    28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Routa Number, City or Town, State)	ete									cor	mpletion of causa	
25. Was case referred to medical examiner?  1	dm						I	7				
examiner?  VE Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residanca 6 Other (Specify)  27. Manner of Death 1 Natural 2 Accidant 3 DOA  28a. Date of Injury (Month, Day Year) 2 Accidant 3 Suicide 4 Homicide  28b. Tima of Injury M 2ccurred  Work?  M 1 Yas 2 No  28c. Injury at Work?		OF Western							2 LA No	1L	JYas Z∐No	
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28b. Linjury at Work? 1   Yas 2   No 28c. Injury at Work? 1   Yas 2   No 28c. Location (Street and Number or Rural Routa Number, City or Town, State)	0	examiner?	Hospital:		_ [	NAL		**				
2 Accident invastigation 3 Suicide 4 Homicide Could not be datermined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State)	-		1 LI Inpatient		ATION 3LI DOA	4 LI NU					()	
	lon	1X Natural 5 ☐ Pending		par) 200. Illi				COUPS HOW III	July Goodine			
	cat	3 Suicide 6 Could not	De Diago el laiun	Athens				ation (Street	and Number	r or Dura	I Route Number	
	T.	datamiaa	289. Place of injury -	At nome, farm Specify)	, street, factory, offic	96				or Mura	Froute William,	
m 1 298, Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.		CO. C. William . T.						1 - 1b	4-3		ato d	
(Check only one)	edicai	(Check only 2 Medicat Exa	miner: On the basis of exa	mination and/o								
29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Me	29b. Signatura end title of certifier	N . A		29c. Lice	nse number		29d. [	Date signed	(Month, I	Day, Year)	
O.C.M.E. April 11, 2000		1 Williams to	melhill			O.C.N	1.E.	Ap	ril 1	1, 20	000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	)	30 Name and address of person until	completed cause of death	(Item 22=1 /T-	me Print)					,		
Margarita Korell. M.D. 111 Penn Street, Baltimore, Maryland 21201				(ताकता दठव) (1)	111 Penn	Street	t, Balti	more,	Maryla	and 2	21201	
	toto			Signature								
State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature 4			Server.		oasto							



# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				1	Ce	rtificate	of I	Death		Reg. No.	10 1	1883
<b>2</b> 1.1.1.	1. Decedent's Na	me (First, Middl	e, Last)						2. Dete of De Month	oth Day	Yeer	3. Time of Death
Physician /Medical	SANDRA	HARVEY					91		APR	3	2000	22:50
Examiner	4a Facility Name	(If not institution	n, give street and nu	imber)			4	lb. City, Town, or L	ocation of Death	4c. Co	unty of Death	
			GENERAL H					COLUMB			IOWARD	
Funeral Director	5. Social Security 218–42-	-9448	6. Sex 1□ M * F	7. Age (In yrs 56	s. last birthdey) Yrs.	Months D	eys	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, De Jan 24,			place (State or Foreign ntry)
A 11	Usuel Residence 10a. State	10b. County		10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
natural; or flams 23a or 28a-f ahow deal Examiner must be nothlight at sted by Funeral Director	MD	Howar	·d	п	ighland						50 45	1 ☐ Yes 2 ☐ No
be nothed Director	10e. Street and N		· u		TRIITAIIC	10f. Zip Co	ode			10g. Citizen	of Whet Cour	ntry?
23a o	7617 G:	reen Del	1 Way			2077	7			USA	A	
of, or items	3 🕅 Widowed	s arried 2 Marri	Armed Fo	2 No		Was Deceden If Yes, specify 1☐ Yes 2☒		ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, ecity: WH1t	etc.
To Be Completed	(Sp	15. Deceden ecify only higher condery (0-12)	st grede completed)	1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use i	fone o	duning most of work	king	16b. Kind	of Business/Inc	dustry
S	12				(	Cafeter	ia	Worker		Food		
Be ve	17. Father's Nam		Last)					18. Mother's Nam			meme)	
To T	Sidney								Jane F			
treumatic event, the Manager To Be Comp	19a. Informant's		hip (Type, Print)					end Number or Rui				
the t	Brian 20a. Method of D			20b.	Place of Dispo			ell Way H	Date Date	-	yland 2 ion - City or To	
	1 Surial		3 □Removel from	State Li	nthicum			cemetery.4	-7-00			Maryland
s the burlet-transit using in a single size of the siz	Immediate Caus disease or condi resulting in deeth Sequentially list if any, leading to cause. Enter Un	e (Final tion )  (conditions, immediate deriving	a. Ac.	Due to	ARDIC	7601 Ster the mode of the mode	and dyin	TORY	Road L or respiretory e	5.5		And 20707 Approximate Intervel Between Onset and Deeth  Nour-
Completed by Physician/Medical		n) Last	d.	leath but not re		nderlying ceus						o the cause of death?
eted by	Radia	fin )	to spine							an autopsy	av	ere autopsy findings railable prior to empletion of cause
omp	5/19	1/58 pc	cetomi						10	Yes 200		deeth?  ☐ Yes 2☐ No
Be Com	25. Wes cese ref							26. Place of Dee				
I director,	examiner?	XNo	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Oth	or	ome 5 Resi		Other (Special	(y)
tlon:	27. Menner of De 1 Netural 2 Accident	5 Pendin	M	of Injury oth, Dey Year)	28b. Time o Injury	f 28c	tnjur Wor	y et k? Yes 2 □ No	28d. Describe	now injury o	ccurred	
Certification:	3 Suicide		ined 288. Place build	e of Injury - At ling, etc. (Spec	city)				City or To	vn, Stete)		el Route Number,
completely filled in by the Medical Certifical	29a. Certifier (Check only one)	Certifying	g Physician: To the Examiner: On the b	e best of my kn pasis of examin oner steted.	owledge, deat etion end/or in	h occurred at t vestigation, In	my o	ne, date and plece, pinion, deeth occur	, and due to the rred et the time,	cause(s) en dete end ple	d menner as s ece, and due t	itated. o the cause(s)
completely filled in by the fune Medical Certification	29b. Signature a	nd little of certifie		Λ Λ		29c. L	icens	e number		29d. Dete s	igned (Month,	Day, Year)
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~						Print)	Pa	toxen+	Parkun	1,00	ionbia	x1021044
State	3APR'I'd	ZUUD Year)	Banker 32. F	Registrer's Sign	nature							

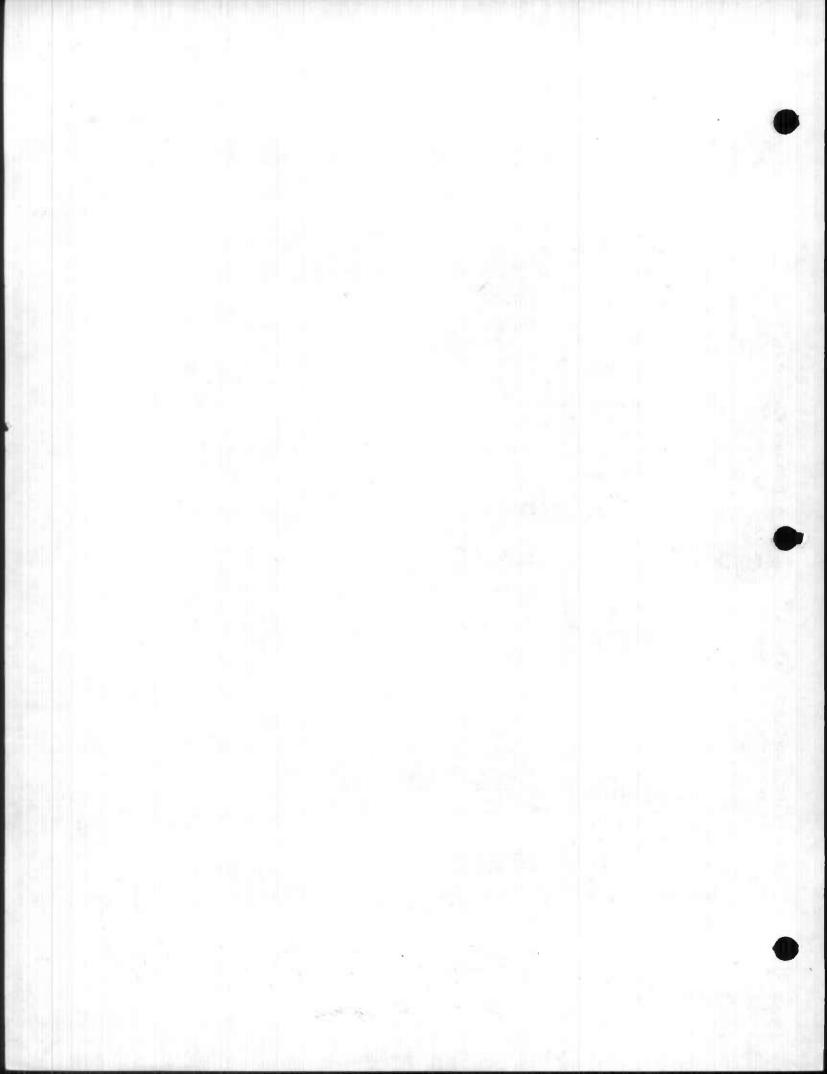


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

					f Marylar		artment rtificate			and M	ental Hyg	giene () Reg. No.	0 1	1884
Physicia /Medic	n Ele	eanor	(First, Middle, La			Harpe	r				2. Date of Dec Month april	Dey 0.8		3. Time of Death  12:30 am
Examine	Ger		not institution, give Eldercomber 6.5	are -	Herita	age Ce			Dunda	alk	cation of Death	Bal	timo	
Funeral Director	220	-20-64	462	1□M 2 <b>X</b> F	7. Age (in yis.	Yrs.	Months	Days	Hours	Min.	8. Dete of Birt (Month, Da DEC 17	,1927	9. Bittip Coun PA	lace (State or Foreign try)
Manyland H ahow	10a. St	tate	10b. County Baltin	nore	11000	ity, Town or Lo undal							11	0d. Inside City Limits 1 ☐ Yes 2 No
ter death with the Maryler Neme 23a or 28s-f ahow ner must be notified at	72	treet and Numb	llers F	Point R	d.	******	10f. Zip	Code 222	2		3,71	10g. Citizen of USA	What Coun	try?
ura at	3 D	ritel Status (Never Merried ) Widowed 4	d 2 Married	12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or De	2 No		Wes Decedent Yes, special Yes 2		lispanic Origan, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		ca - Americ ck, White, o	etc.
d within 72 hours af giene. or than "natural", or	Elem 1		5. Decedent's E y only highest gra dary (0-12)		-4or 5+)	16a. Dece (Give life,	dent's Usual kind of work DO NOT us	l Occup k done e retired	nation during most d)	t of worki	ng	16b. Kind of B	usiness/Inc	lustry
	6   17. Fat	2 yrs	irst, Middle, Last n Harpe	4 yrs		Regi	stere	d D	18. Mothe	r's Neme		Hospi Maiden Sumen Tressl	ne)	
and 2 sh alth and 27 la m			ne/Reletionship (		ster							more, N		
Semil. Pages 1 a Department of He mportant: If Hear ny Injury or othe	1)	ethod of Dispo Burial 2 Donetion 5	sition Cremetion 3 [ Other (Specif	Removel from :	Stete Sa	Place of Dispo cemetery, cre CIED	psition (Nam metory or ot Heart	ne of ther place	Jes	us	pr.11 2000	20c. Location		
permit. Departminports eny injures	1	Sol	Washing Licer	(0)	7	7	110 S	soll	lers	Poi	nt Rd.			,P.A. Md. 21222
Physician /Medical Examiner	Immed diseas resultir	fiate Cause (Fi e or condition ng in deeth)		. SEV	ERE Due to (	CAR or es e consec 1 VE	DIO quence of): HEA		_	TH	Y -URE			Interval Between Onset and Death
ficsta be physicies the bur	Cause that ini resultir	ntially list cond leeding to imm Enter Underly (Disease or in tieted events ng in death) La		a. 1 NS	CLIN Due to (c	or es a consec	PEM puence of):	DE.	KT	DI	ABETI	ES M	ELLI	TUS
d by th	Part II.	Other significa	ant conditions c	contributing to de	ath but not res	sulting in the u	nderlying ce	ouse giv	ven in Pert I.		23b. Did 1	1657111		the cause of death?
ne law requires the has been signed 2 should be o	Completed b									-		an autopsy med?	ava	ere autopsy findings allable prior to mpletion of cause death?
F # 6	25. We	s case referre	d to-medicel						26. Place	of Death	1 Check only o		1 🗆	Yes 20 No
F	0 1	miner? Yes 2 N	0	Hospitel: 1 🗆 I	npatient 2	] ER/Outpatier	nt 3□ DO/	A Oth	ner: 410 Nu	ırsina Hor	ne 5□ Resid	lence 6 Oth	er (Specifi	v)
£ £ 2	27. Mar 0 1 2	nner of Death   Netural   Accident	5 Pending investigation	n	of Injury h, Day Year)	28b. Time o Injury	f 28	Bc. Injur Wor 1 🔲	- Allendary	2		now injury occur		
ital or Attending urs after death. rel Director: After lied in by the funa	40	] Suicide ] Homicide	6 Could not b	286. Piece buildir	ng, etc. (Speci						City or Tou	m, Stete)		il Route Number,
To the Hospital Within 24 hours a To the Funeral completely filled	9	theck only 2 ine)	Certifying Ph	nysician: To the niner: On the ba and mann	sis of examina	owledge, death ation end/or in	vestigation,	in my o	pinion, deal	d place, e th occurre	ed et the time,	date end place,	and due to	the cause(s)
To T	29b. Si	gnetuja and tit	le of certifier	红了	WILL	MO	29c.	Licens	7/8	28		29d. Date signe	d (Month, i	Dey, Year)
8	Sat	ind	ed person who	uma	2 M	arte	Print) Pl	Pe C	1 B	illi p	core	MD:	2-122	22
State	S COLUMN	e tiled (Month,	PR 12 2	.000 32. R	ojstrar's Sign	ature &	de	on	6					

DHMH 16 Rev 6/95

Registrar



State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) APR 1 2 2000

I HEODORE MILLI

29b. Signature and title of certifier

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

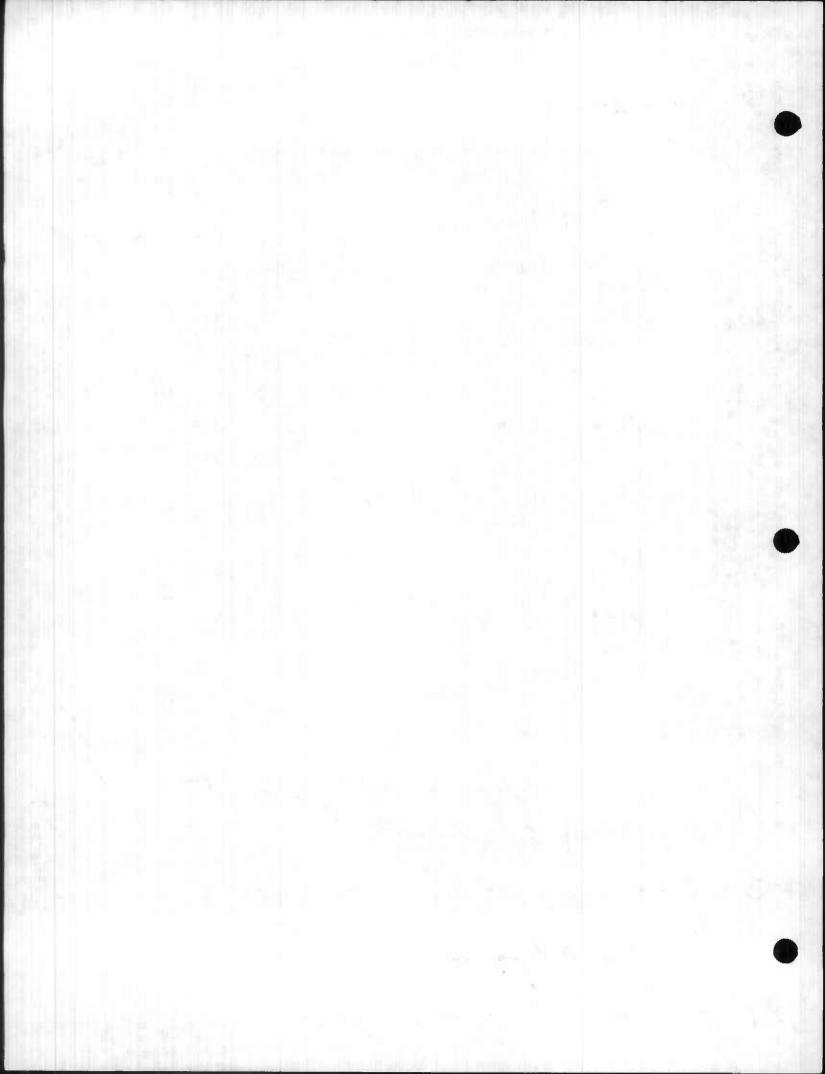
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

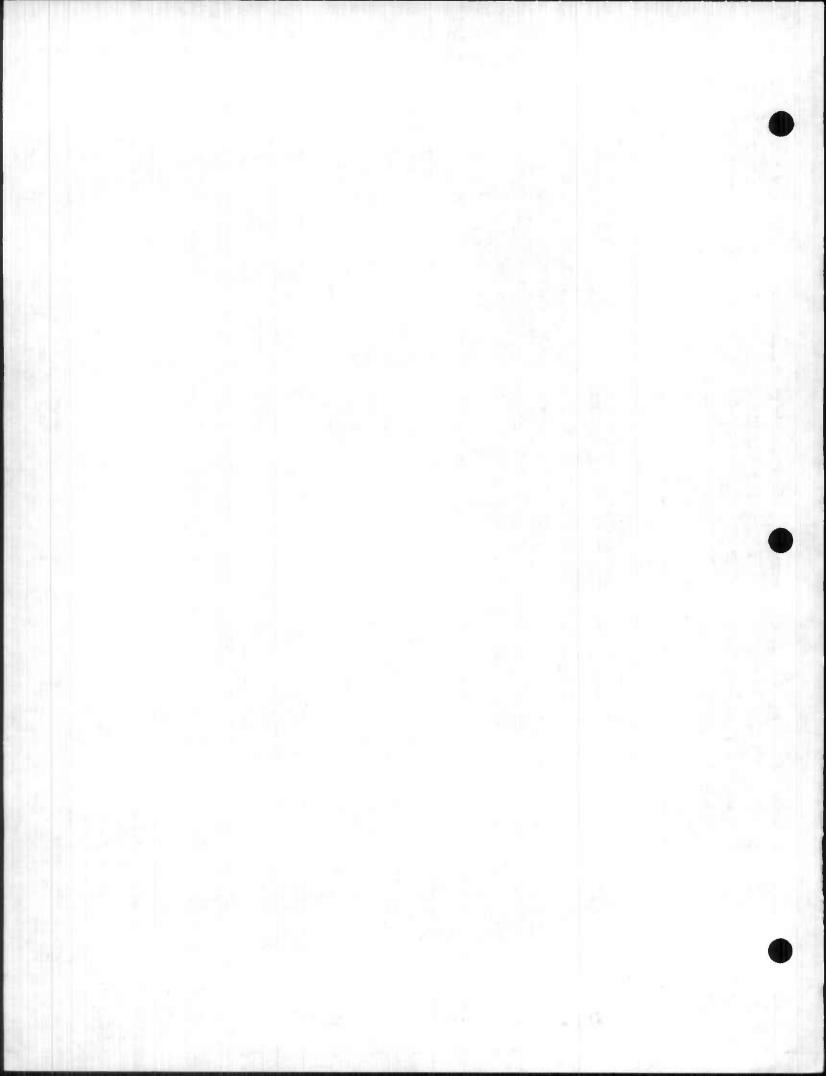
29d. Date signed (Month, Day, Year)

APRIL 6, 2000



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) \(\Omega\)

	Certificate of Death		Reg. No.	11886						
Physician	D.: D.: 11 0	2. Date of Dea Month	Day	3. Time of Death						
/Medical		+PRIL		2000 2:37 Am.						
Examiner	4a Facility Name (If not institution, give street end number)  4b. City, Town, or Loca  HARBOR HOSPITAL CENTER  BALTIN			Death						
Funeral Director	5. Social Security Number 225-32-8574  Outline F	Month, Des	7. Year) - 32	9. Birthplaca (State or Foreign Country)						
daryland t show sd.st. or	10e. State 10b. County 10c. City, Town or Location  MD NA BALTMORE			10d. fnslde City Limits 1 ☑ Yas 2 ☐ No						
or 28e-f s be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	nat Country?						
	2913 VIOLET AVENUE 21215			SA						
D20 on all	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Datas:  13. Was Decedent of Hispanic Origin? (Specifi Yas, specify Cuban, Mexican, Puerto Ri	ify Yas or No- ican, etc.)	Biack,	- American Indian, White, atc.						
21215-0020 ed within 72 hours at spierre ar natural, or or than "natural, or t, the Medical Exam Completed by f	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  OTH GOADE  16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifta. DO NOT use ratired)  CARRIER	7	16b. Kind of Business/Industry  NSA							
	10 TH GRADE N/A CHRRIEK  17. Father's Name (First, Middle, Last)  18. Mothar's Name (i	First, Middle,								
Maryland 12 should be file 12 should be file 12 should be file 13 smarked othe Traumatic event	BURNIE HAMILTOIN, SR. GRACE 1	PAGE.								
View Manual Land	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addrass (Street end Number or Rurel I		r, City or Town, S	itata, Zip Coda)						
M md 2	ERIC HAMILTON   SON   1453 GORDON DR., GLEN	J BUR	WE. M	D. 21061						
Tore of the or other	20a. Method of Disposition  1	Date	20c. Location - C	STOWN, MD						
Baltim permit. Pa Department Important any injury once.	21. Signature of Funeral Service Licensee U 22. Nama and Addrass of Facility VAUGHN C. GREBUE	FUN	IERAL S	ERVICE						
	55 BAUD. NATI P	IKE, E	BAUTO. (	NO. 21229 Approximate						
Physician //	23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Interval Between Onsat and Daath						
Examiner	disease or condition resulting in death)  a. ACUTE MYDCARDIAL INF.  Due to (or as a consequence of):	ARLTI	ION	10 min						
je z	END STARE RENAL DISE	ME		6 YRS.						
68760, ficate be executed physician and is the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
OX centi	resulting in death) Last  d.									
_	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.	23b. Did t	N.4	ribute to the cause of death?						
C X TO	DIARETES MELLITUS		Min							
Sord requir should	HYPERTENSION, SICK SINUS EYNDRONG	24a. Was perlo	an autopsy mad?	24b. Were autopsy findings available prior to completion of causa of death?						
E & 400		101	as 2 No	1 Yas 2 No						
Vital I Incelor: The certificate rector, pag	25. Was case referred to medical 26. Placa of Death (	(Check only o	ne)							
- K 50 C	axaminer? 1 Yas No Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Resid	dence 6 □Otha	(Specify)						
C & 5 5 2	27. Manner of Death 1 De Natural 5 Pending (Month, Day Year) 2 Accident invastigation 28a. Data of Injury 28b. Time of Injury Work?  M 1 Yes 2 No	8d. Describe h	now injury occurre	d						
Division of the or Attending P as a first death.  al Director: After the funers led in by the funers Certification:	3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, afc. (Specify)	8f. Location (5 City or Tox	Street end Numbe vn, Stete)	r or Rurel Route Number,						
ne Hospi n 24 hou Ne Funer pletely fill edical	29a. Cartifiar (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, an Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred and manner stated.									
To the within	29b. Signature figit le of certifier RESIDENT. 29c. Licanse number D0055481		APRIL	(Month, Day, Year)  OG 2000						
6	30. Name and address of person to completed cause of death (Itain 23a) (Type, Print) 3001 500714 SHWE MRA GYNW, M.D BALTIMEIZ	MAN	DIVER 212	STREET						
State Registrar	31. Date filed (Month, Day, Year)  APR 1 2 2000   32. Registract Signatura									



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** APRIL 2000 11:00 AM 0 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner 600 FRANKLIN STREET LTIMORE If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) PENNSLY VANIA 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 12 M 20 F 5110 Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Madical Examinar must be notified at 1⊠Yes 2□No MARILAND BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 3600 RANKLIN STREET Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yes 2 No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 14. Race -11 Merital Status Bleck, White, etc. 1 Navar Merried 2 Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry The marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) RIVER 12 +#GRADE 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Nem 27 is marked of any Injury or other traumatic eve JIMMY UNKNOWN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 W. FRANKLIN ST. BALTIHORE, MD-2R29 of Disposition (Name of Date 20c. Location - City or fown, State HELMA WATERS! FRIEND 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Burial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST CEME, 04-12-00 OWINGS MILLS, MD. 22. Name and Address of Facility BROWN JR. F-UNERA. JOSEPH H. BROWN JR. F-UNERA. 2140 N. FULTON AVE. BALTO, MD. 21. Signature of Funerel Service Licensae WN JR. FUNERAL HOME 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel 2 MONITH diseese or condition resulting in deeth) a MINTASTATIC CAN Examiner Due to (or as e consequence of): Physician/Medical Examiner sician and burial-transit Sequantially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted avents resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of) the th 080 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert II. 1 Yes 2 000 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) No No Certification: To 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Neturel 2 Accident 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

68760 Box Records, P.O. of Vital Division The law requires that the death certificate be assocuted

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To the F within 2

**DHMH 16 Rev 6/95** 

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Sattimore, Maryland

show

State Registrar

Medical

29e. Certifier

(Check only one)

29b. Signeture and file of certifiar

31. Data filed (Month, Dey, Year) APR 12

FRAS 32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

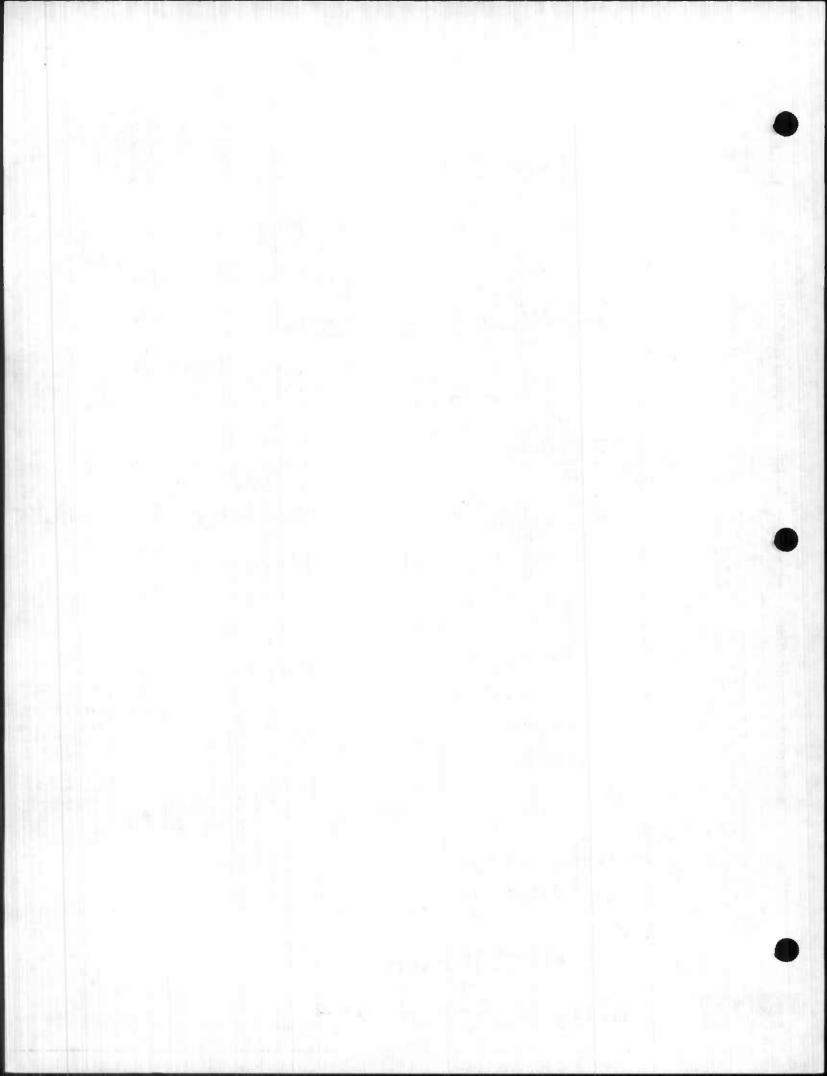
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Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

[2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

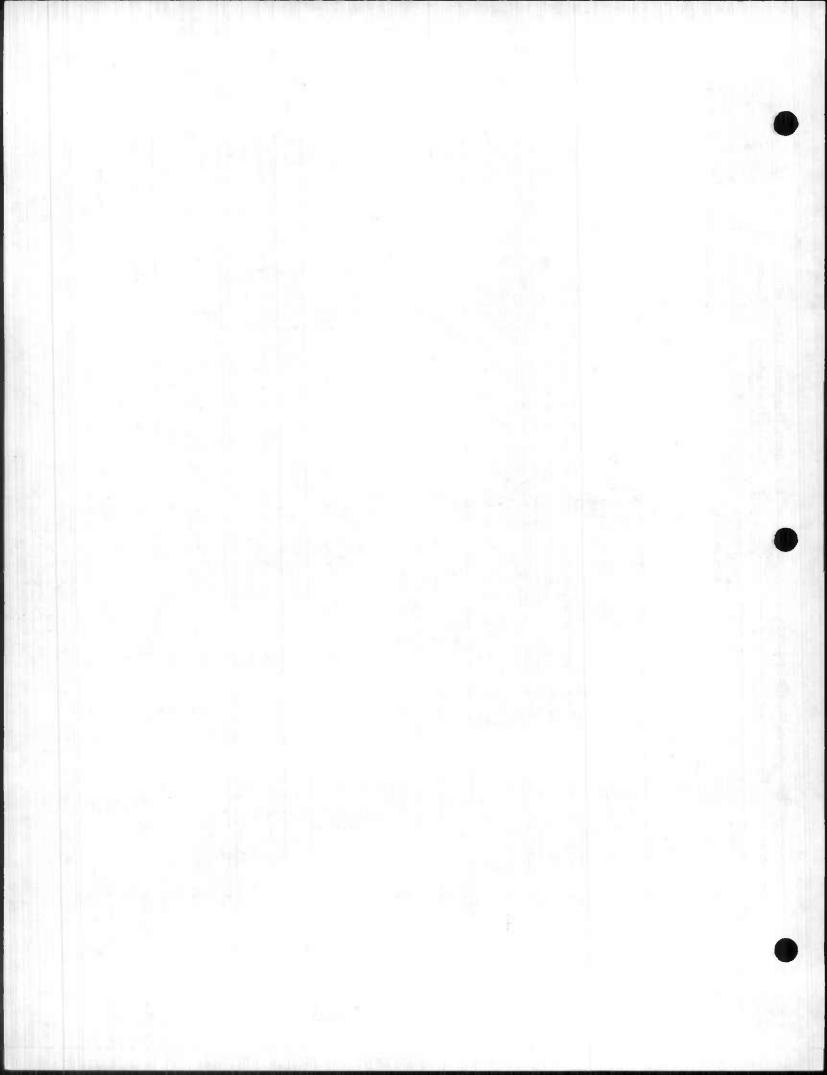


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10,2000 Month **Physician** 1:15 pm April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 940 S. LAKEWOOD AVENUE APT. 110 BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Oct. 30,1923 If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Hours 1∭M 2□ F 214-14-4576 MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location Was 2 No Directo 280-1 MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 940 S. LAKEWOOD AVENUE APT. 110 21224 Funeral S .A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No K Yes, Give Year or Dates: 1942–46 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) o filed within 72 hours after di if Hygiens. other than "natural", or flam 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRESSMAN METAL FABRICATION permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If them 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 JOHN W. JENKINS, SR. MARY LOUISE EVERETT 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 S. LAKEWOOD AVENUE, BALTIMORE, MD. MARY P. JENKINS/ WIFE 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CEMETERY 4/12/00 BALTIMORE, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Batween Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Box 68760, physician a the burial Physician/Medical The lew requires that the death certificate mic obstrutile lung Difeque 080 P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Records, Š 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 20 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 No Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Medical Certification: To 1 Yes After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 1-D Naturat 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 3 relais 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Vaar Natwerlal S. Jani 2000 26, 9:30 am March 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10485 Owen Brown Road Columbia Howard If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Ye 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) ₩ 2□ F Months Deys 82 356-52-0627 June 4, 1917 India Usual Residence of Deceden 10b. County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10485 Owen Brown Road 21044 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married Specify: Asian Indian 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Medical DOctor Health 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Shiva Shanker Jani Jekorba Pandya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 10485 Owen Brown Road Columbia, Maryland 21044 Niranjan Jani 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crem. 3-27-00 Laurel, Maryland 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Signatura of Funeral Service License 22. Nama and Address of Facility Fleck Funeral Home Inc. 7601 Sandy Spring Road Luarel, Maryland 20707 Do not entar the mode of dying, such as cardiac or respiratory errest. Approximate one that caused the death. Intarval Batween Onset and Death Immediata Causa (Finel diseasa or conditio rasulting in death) Dua to (or as a consequence of

**Physician** /Medical **Examiner** 

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Pages 1 and 2 should be 1 hent of Health and Mental I

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Department of Important: If any injury or

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Baltimore, Maryland 21215-0020

Director

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Examiner Sequentially list conditions, if any, laading to immediate cause. Entar Undarfying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medical

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Dua to (or as a consequence of) Dua to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 25. Was casa rafarred to producal axaminar? 26. Place of Death (Check only one) 3.00 No Hospital: 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of injury (Month, Day Year) 27 Manner of Death 28b. Tima of 28c. Injury at Work? 1 Matural 5 Pending invastigation

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Ware autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death?

1 Yas 2 No 1 Yas 2 No

Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and mannar stated. (Check only one) 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) D40343

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

MD 21207 Sheft MD Kernan 2200 DONALD 31. Data filed (Month, Day, Year)

State Registrar

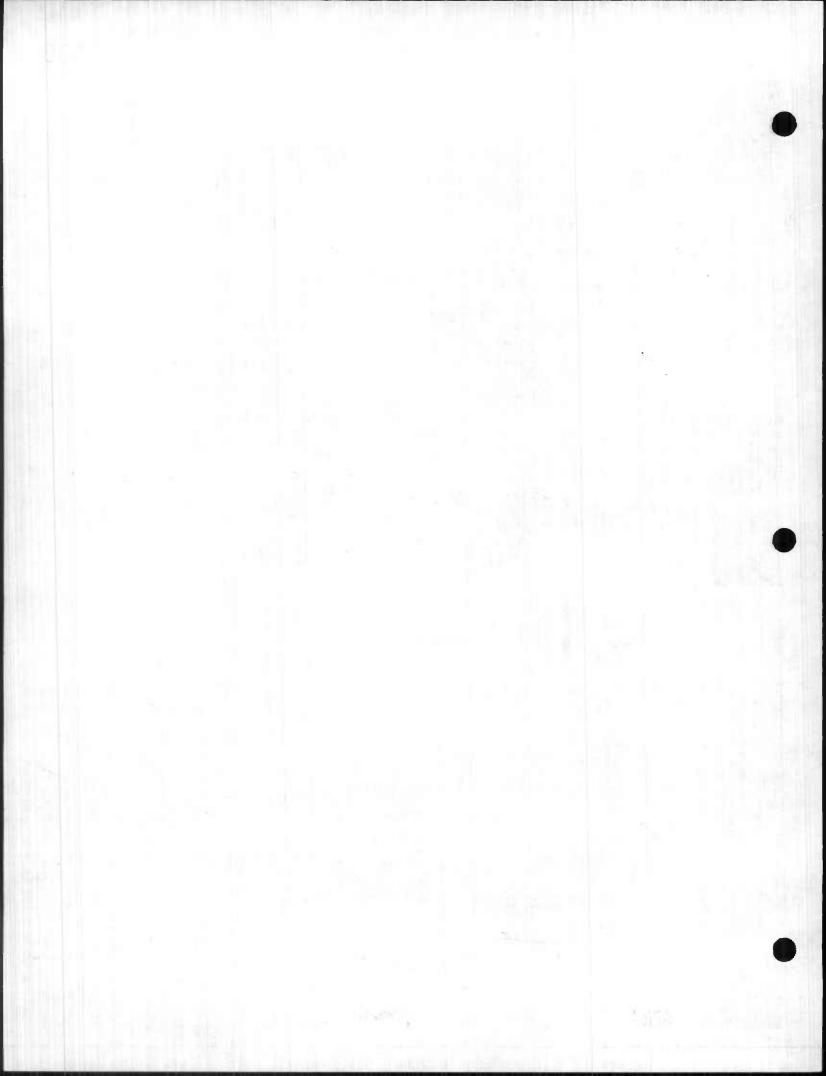
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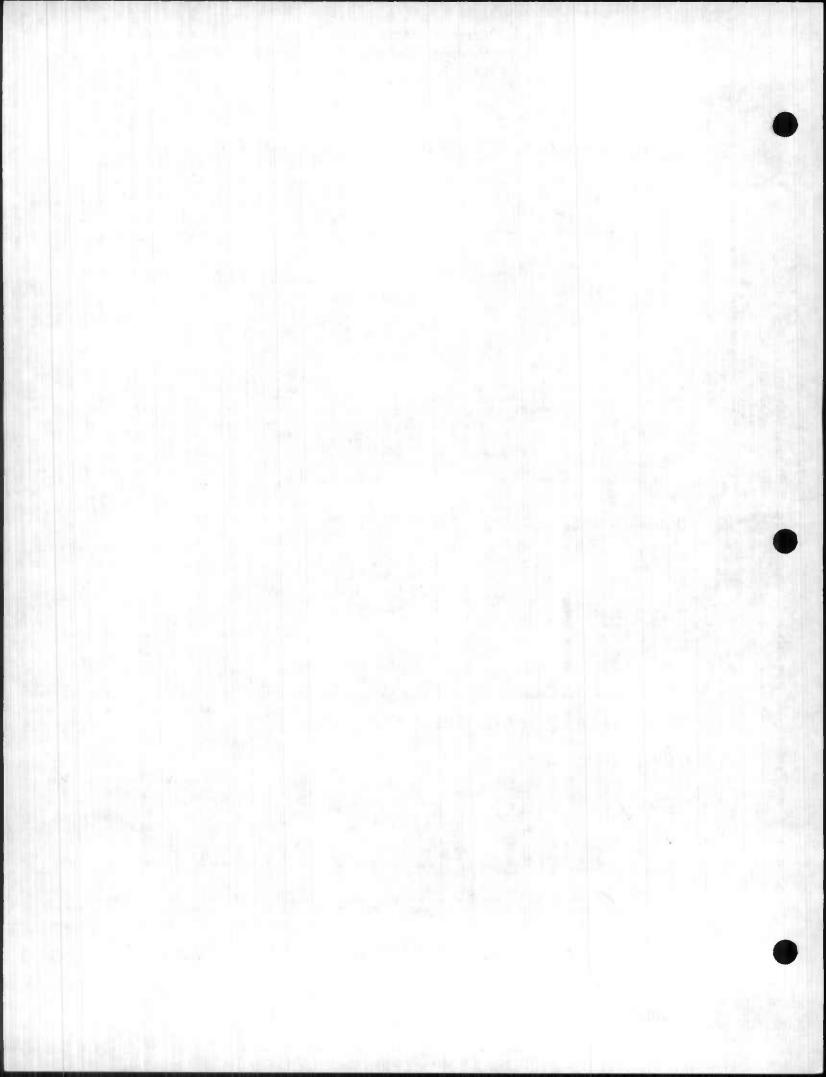
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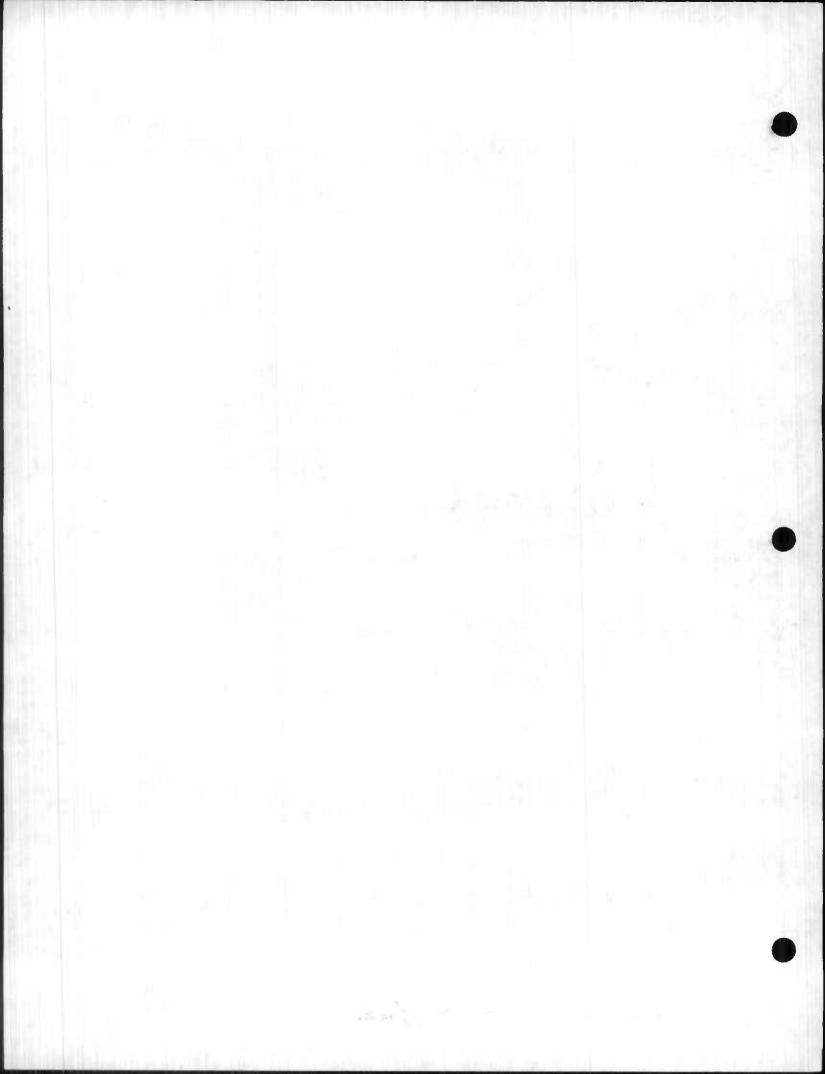
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al or	5. Social Security Number 215–24–9188  Usuel Residence of Decedent	1	s. last birthdey) If Ur Yrs. Mont		Hours Min.	8. Dete of Bi (Month, D	1930	Birthplece (State or Foreign Country)  Md			
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Director	10e. Street end Number	11/α	10f.	Zip Code	LIMOIC		10g. Citizen of V				
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by Funeral	11. Merital Stetus  1.□ Never Merried 2 □ Merried  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces?  1  Yes, Give Armed Yes, Give Armed Yes, Give Armed Yes, Give Armed Yes or Detes:		ecedent of I specify Cub s 2 No	dispanic Origin? (S) en, Mexicen, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify	e - American Indien, kk, White, etc.			
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	19e. Informent's Neme/Reletionship Carolyn Henson	(Type, Print) Daught			end Number or Ru ton Stree						
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petery filled in by me funeral director edical Certification: To Be	25. Wes case referred to medical examiner?  1   Yes   Yes   Yes    27. Menger of Death 1   Neturel   5   Pending investige   2   Accident   Gould no determine    29e. Certifier (Check only one)   Certifying   29b. Signature and address of person we    30. Name and address of person we	28a. Dete of Injury (Month, Dey Year) tion t be ad 28e. Plece of Injury - At building, etc. (Spec  Physician: To the best of my kr aminer: On the basis of examinand menner steted.	28b. Time of Injury M home, ferm, street, faithfy)  nowledge, deeth occuretion and/or investige	28c. fnju Wo 1 Ctory, office	ner: 4 Nursing H ry at rk? I Yes 2 No me, date end place opinion, deeth occu	perfusith (Check only) tome 5 Res 28d. Describe 28f. Location City or To	Yes 2 No one) idence 6 Oth how Injury occur (Street end Numb wm, Stete) e ceuse(s) and ma , date and place, 29d. Date signe	aveilable prior to completion of cause of death?  1  Yes 2 No  er (Specify)  red  per or Rurel Route Number,  anner es stated. and due to the cause(s)			



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			ried 2 Married	1 🗆 Yas If Yes, Gir	VB		1 Yes	No No	Specify:		Specif	y: 51	ack
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EĘ		19e. informent's N	leme/Relationship	(Type, Print)		19b. Ma	iling Address	(Street	end Number or R	ural Route Numb	er, City or Town	, Stete, Zip	Code) 212
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other	+	20e. Method of Dis		001	20b.	Plece of Dis	position (Ne	ne of		Date	20c. Location		
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sician		/spock, or her	ert fallure. List only	one cause on e	each ma							1	Onsal and Deat
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miner		resulting in death)	on	e/V	IASS LV-	e m	40 cato	ial	INFORC	tion		-	X I day
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the atta	를 등	Part II. Other signi	ficant conditions	contributing to de	eath but not re	sulting in the	underlying o	ause gi	ven in Part I.	23b. Dld	tobacco uae co	ontribute t	o the cause of d
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has t ge 2 s	g.											ol	death?
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ctor.		25. Was case refe examiner?	rred to medical						26. Plece of De	ath (Check only	one)		
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led in by the funera Certification:	6	4  Homicide		buildi	ing, etc. (Spec	eity)				City or 10	wn, Stete)		
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tely fely	edicai	(Check only one)		miner: On the b	asis of examin				opinion, deeth occ				
complately filled in by the	-		total a state	and men	ner stated.		- 00	Lines	an number		20d Data sign	nd /Month	Day Veerl
9 0	-	29b. Signature end	title of certifiar		/				sa number		29d. Dete sign		Day, Tear)
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201)	-	30. Neme end add	ress of person who	completed caus	se of death (Ita	m 23e) (Typ	e, Print)		-000		1	1	
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Registrar	1	WLL T	A LUUU	A. P. Commercial Comme	/~	, Kly	VULLO						



# ACKEW

1. Decedent's Neme (First, Middle, Last)

Month April 5.02 A **Physician** JACKEWITZ ALVINA 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Sten Burni e If Under 24 Hrs. 8. Dete lariner Healt Anne Arundel If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 F 219-01-2467 80 Director March 26,1920 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahon Maryes 2 No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 1519 Elrino Street 21224 United States Funeral Hems : 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or iter the Medical Examiner Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes ŽIXNo Specify: by Specify 3E Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools 8 Years Custodian Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 should be f Pages 1 and 2 should nent of Health and Men Joseph Wagner Anna Sommers: 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Schepleng (Daughter) 9 Township Road Dundalk, Maryland 21222 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 5 = 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or DOCS. 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 4/10/2000 Baltimore, MD 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signeture of Funeral Service Licensee OC 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical the Due to (or es a consequence of) signed by the attending the detached for use Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Plabetes mollitus Records, by Completed 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medicet Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide tell Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and the of contilled 29c. License number 29d. Date signed (Month, Dey, Year) Attending D44973 2000 hysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 HOSPETAL DRIVE SUITE -5. SAWHNEY GURMEET MD GLENBURNIE, MD 21061 31. Date filed (Month, Day, Year)
APR 1 2 2000 32. Registrar's Signeture State

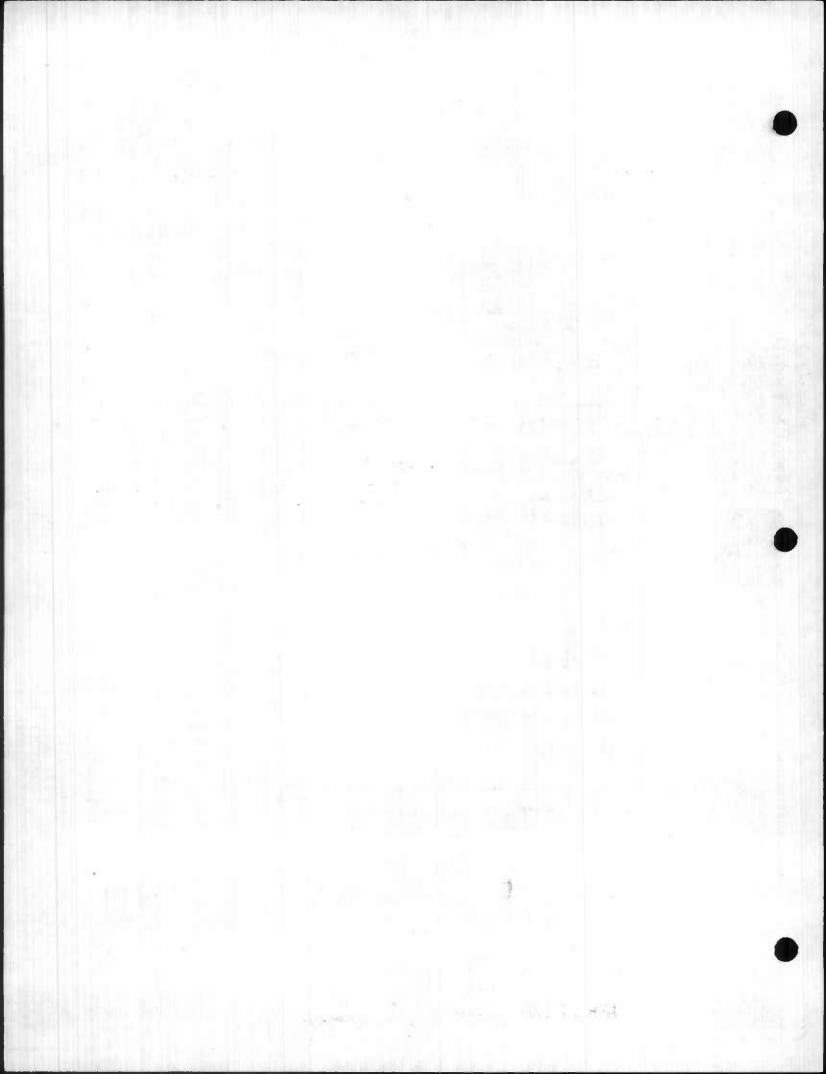
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

**DHMH 16 Ray 6/95** 

Registrar

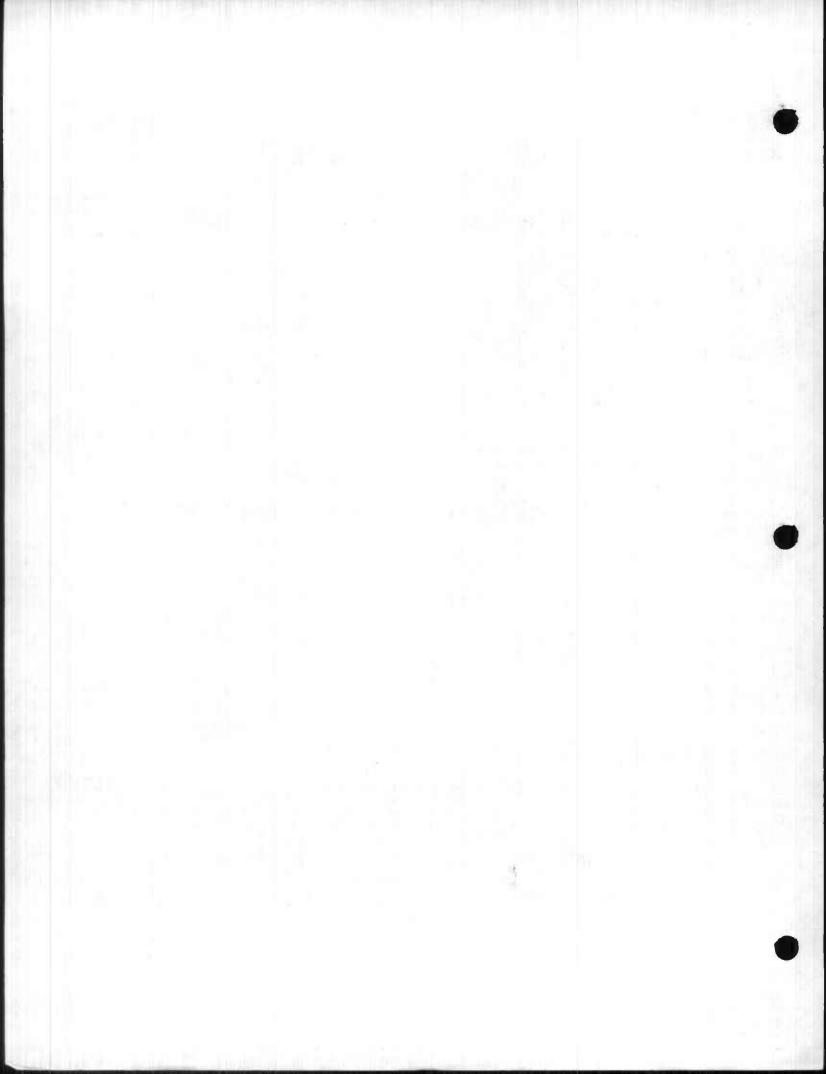


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State of Maryland / Department of Health and Mental Hygiene
Cortificate of Death

					Cel	uncat	e or i	Death			Reg. No.	U	1000
	1. Decedent's Nama	(First, Middle, La	est)						1	2. Date of De	eath		3. Time of Death
nysician	Marie J.	Клател								April	7. 2000	Year	6:45 a.r
Medical kaminer	4a Facility Name (If		e street end nu	mber)			4	b. City, To	wn, or Lo	cation of Deal		y of Death	
lannier	12023 Ea	stonn Au	ONIIO					Balt	iman	0		timor	
	5. Social Security Nu			7. Age (In yrs. I	lest hirthdey)	If Under	1 Year	If Under:			th Duc	9 Righ	
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	Usual Residence of I	10b. County		10c City	, Town or Lo	cation							10d. Inside City Lim
ner must be notified at uneral Director	Maryland		Baltimo		,		timo	re					1 🗆 Yes 2💥 I
a si	10e. Street and Num	ber				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
al la	12023 Eas	tern Ave	enue					2122	0		u.	S. A	
iner must	11. Merital Stetus		12. Was Deck	edent Ever in U,	S. 13.	Was Deced	dent of H	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	o- 14. Ra		can Indian,
by F	1 ☐ Nevar Marrie 3 🏿 Widowed 4		1 Tes	2 X No		1 Yes		Specify:	, rueno	rucan, etc.,	Speci	ack, White, ity:	hite
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To B	Karel C	epl						Ва	rbar	a Vanw	ıa		
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for us	Pert II. Other algoriffc	cant conditions of	a	eath but not resu	ilting in the u	nderlyina c	ause civ	en in Part t		23b. Did	tobacco use c	ontribute 1	to the cause of dea
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page 2 should be d	25. Was case referre examiner?		Hospitef:				Oth	or		1 (Check only	Yes 2 XNo	ar co	vallable prior to ompletion of cause I death?
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ORIGINAL



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Day, 2000 Month 2:43 AM JOSEPH KIRTSCHER EDWARD 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore 4a Facility Name (If not institution, give street and number) Towson Saint Joseph Medical Center If Under 1 Yeer | If Under 24 Hrs. Months | Days | Hours | Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 10XM 20 F 215-34-8946 60 Maryland 9. 1939 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 3035 Balder Avenue 21234 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 1 ☐ Never Married 2 Y Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Dispatcher Transportation 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First Middle Last) Edward Kirtscher Margaret Jenkins 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (wife) 3035 Balder Avenue, Baltimore, MD Mrs. Jocelyn A. Kirtscher 21234 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 D Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4/11/00 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, llece a. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death 1 HOUR MYDCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): CARDIOVASCULAR DISEASE ARTRIAL SCLEROTIC Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of death? 1 🗆 Yes 2 No 2 No 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

28a-f

Nerna 23a or

b

Hygiens. other than

Pages 1 and 2 should be fit ment of Health and Mental H tant; if hem 27 is marked oth lury or other traumatic even

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner sician and burial-transit The law requires that the deeth certificate be axecuted physician s the buria P.O. Box 68760, Physician/Medical 50 á should be deta Division of Vital Records, Completed by page 2 certificate or Attending Physician: Be Certification: To this Affer 24 hours after deeth.

Funeral Director: A

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Manner of Death Netural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and one investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifi-

29c. License number D 23984 29d. Dete signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

7601 OSLER DRIVE, TOWSON, MD 21204 JOSEPH GRANT, M.D., 31. Date filed (Month, Dey, Year)

State Registrar

filled in by

completely

Medical

Hospital

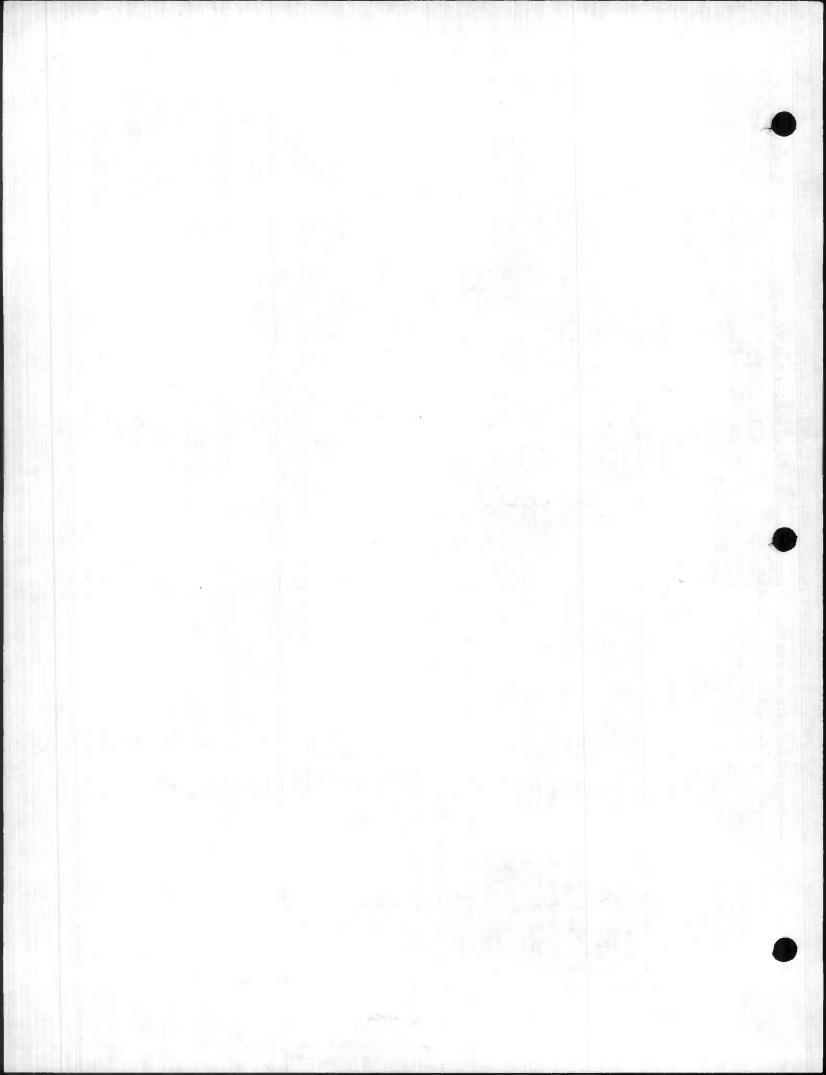
within 2 To the

2000



32. Registrar's Signature

Darks



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Khang Month. Year MOri 06:55A P001a 10,2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) xultimore City Hopkins 6. Sex The Johns If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days 1□M 2☑F 40 214-49-7241 Afganistan Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Columbia . 1 ☐ Yes 2 ☑ No Howard 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7022 Dasher Farm 21045 Afganistan Ct 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2€ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hair Salon Shampoo Person 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vishna Khana Behary Kapur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7022 Dasher Farm Ct., Columbia, MD 21045 Kumar Khana/Husband 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Baltimore Wash. Crematory4/12/00 Laurel, MD 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses itte 5555 Twin Knolls Rd., Columbia, MD 21045 23a. Part1. Enter the disease, or complications that exised the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Sepsis Due to (fr as a consequence of): disease or condition resulting in death) 1 ymphoblustic Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

Be 2 MD

**Funeral** 

Director

ul Hygiene. other than "natural", or items 23s or 28s-f show vent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item any injury or other treumatic event, tre Medical Energy and DOCE.

Baltimore, Maryland 21215-0020

death with the Maryland

The law requires that the death certificate be axecuted ician and bunal-transit physician s the buna Box 68760, 88 080 signed by the a P.O. Records, certificate Division of Vital or Attending Physician: After this funeral death.

Physician/Medical Àq Completed Be Certification: To

Examiner

24 hours after deat Funeral Director: Hospital Medical within 2 State Registrar

filled in by

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Naturai 2 Accident

3 Suicide

29a, Cartifier (Check only one)

4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

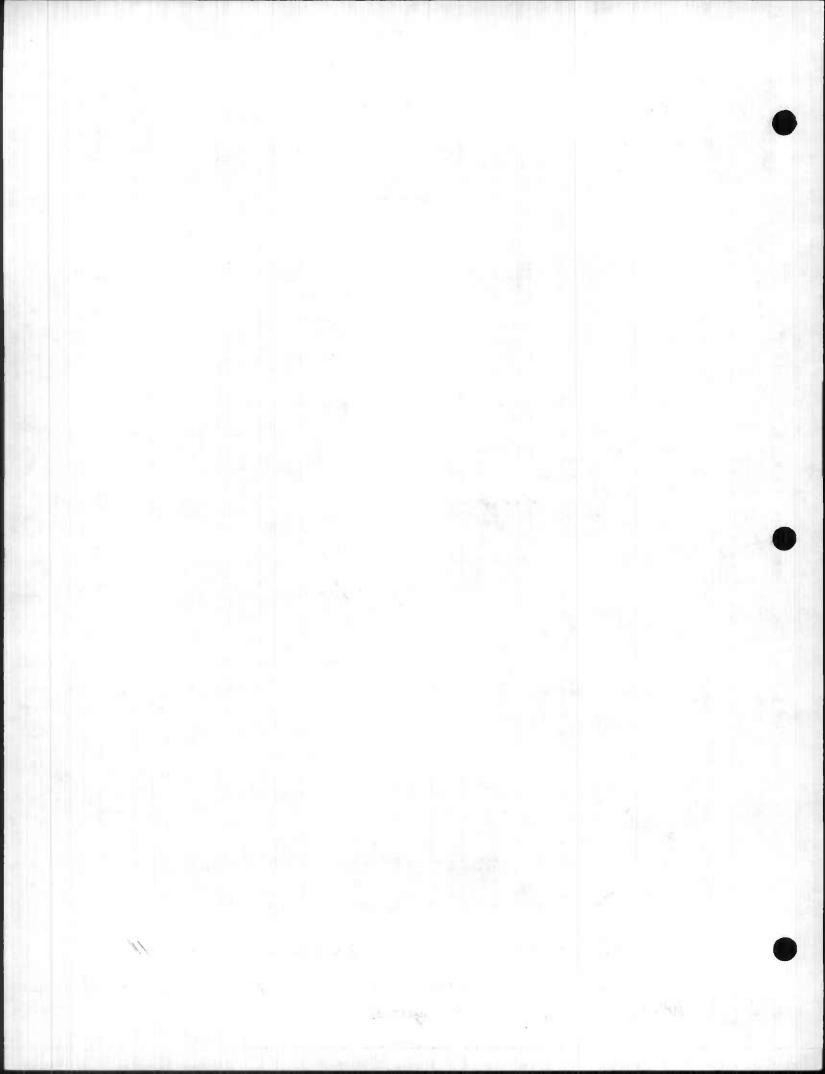
29b. Signatura and titla of certifier Isah M.D. /Ph.D

RES- OOC

29d. Date signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. Wolfe St. Baltimon, MD 21287 M.D. /Ph.D. Dinke Charles G. APR 1 2 2000 32. Registrar's Signature ooks



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Physician Klinedinst Violet April 10, 2000 4:45 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Baltimore Dundalk Genesis Heritage Meridian Eldercare Ctr. 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 1□M 2QF Yrs. 075-12-2399 Sept. 16,1912 Director Pennsylvania Usuel Residence of Decedent notified at 10a, Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 7232 German Hill Road 21222 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. hours after 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva 21215-0020 8 1 ☐ Yas 2 ₺ No Specify: Specify: à White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry filed within 72 Hygiens. other then Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Manufacturing 12 Years Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important! If them 27 is marked other any Injury or other traumatic event apple. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 88 Michael Skodis Bernice Stanadhees 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen B. Crossett (Niece) 2807 Southbrook Road Dundalk, Maryland 21222 altimore, 20b. Place of Disposition (Nama of 20c. Location - City or Town, Steta 20a. Method of Disposition Data cematary, crematory or other place) tXBurial 2 ☐ Cramation 3 ☐ Ramoval from State Sacred Ht. of Jesus Cem. 4/13/2000 Dundalk, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Faneral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Cur 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the ordinase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart to true. List only one cause on each line. Approximata Interval Between Onsat and Death Physician MYOCANDIAL INFANCTION /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner SCVI The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of): and P.O. Box 68760, Dua to (or as a consequence of) 80 08N signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 POnknown Division of Vital Records. à 24b. Wara eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate 1 Yas 2 TING 1 ☐ Yas 2 ☐ No or Attending Physicien: funeral director, Be 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yas 2 TUNO Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending 1 Affetural efter death. Director: Af invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide Hospital or Atta
 24 hours effer de
 Funerel Directo 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, end dua to tha cause(s) and manner as stated Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner steted. 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifie, 29c, Licensa number A23530 4-10-00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 3927 Annapolis Road Baltimore, Maryland Dr. Chattergee 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

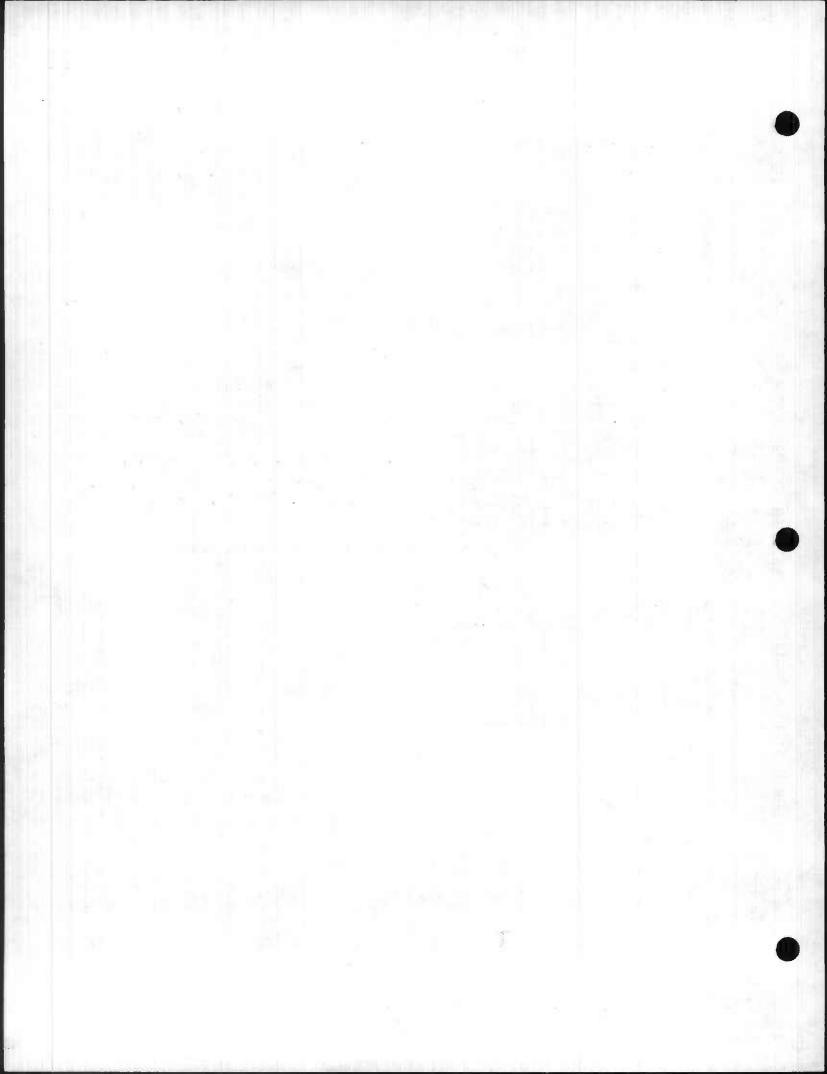
**DHMH 16 Rev 6/95** 

State

Registrar

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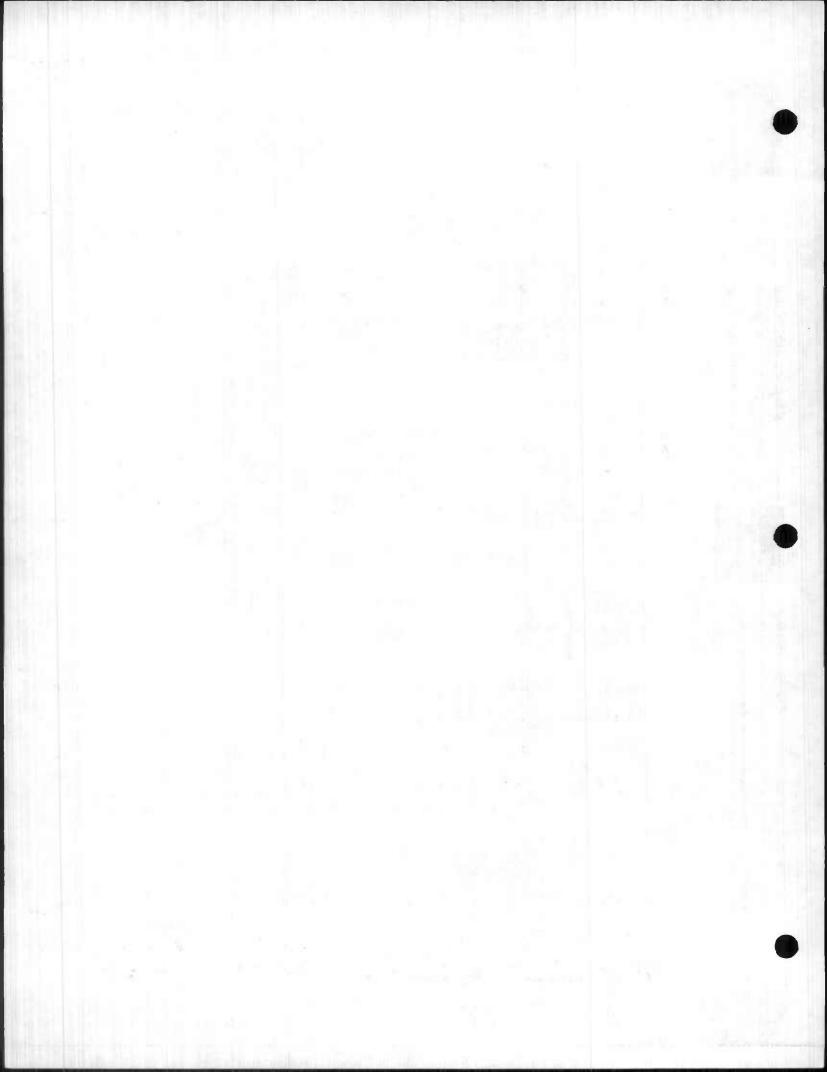
Sparks!



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 515 AM duan 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins 5. Social Security Number altimore
Il Under 24 Hrs. 8. Dete Himore # Under 1 Year 8. Dete of Birth (Month, Day, Year) 9. Birthplece (Stete of Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 233-18-5499 84 Director Sept.19,1915 W. Va **Usual Residence of Decedent** death with the Maryland 10s State 10b County 10c. City, Town or Location 10d. Inside City Limits ahom MD Baltimore Dundalk 1 ☐ Yes 2 No Director must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3514 Louth Road 21222 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 DKYes 2 □ No 11 Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Nema ; 14. Race - American Indien, 11 Marital Status 'natural', or her Black, White, etc. filed within 72 hours effer 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify Specify: White À 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry The Me then Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Rod and Wire Technichan Steel . Pages 1 and 2 should be filed w tment of Health and Mantal Hygie tant: If Item 27 is marked other ti jury or other traumstic event, to Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Charles Loque Edna White 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Judith Stevanus daughter 209 Oakwood Rd, Dundalk, MD. 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Apr 14 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) pemit. Page Department of Important: If any injury or page. Oak Lawn Cemtery 2000 Dundalk, Md. 22. Name end Address of Facility
Connelly Funeral Home of Dundalk, P. A. n of Funeral Service Licenses 7110 Sollers Point Rd. dundalk, Md. 21222 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart laifure. List only one cause on each line. Physician /Medical Immediate Cause (Finel 18 months disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certilicate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buriel Box 68760. Be Completed by Physician/Medical Due to (or as a consequence of) for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Gastrointestinal bleed, congestive 24b. Were autopsy lindings aveilable prior to 24a. Wes en autopsy performed? completion of cause of deeth? ventilator dependent, senal insuti 1 Ves 2 No 1 Tyes 2 No certificata Division of Vital funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the state 28a. Date of Injury (Month, Day Year) 27. Manngrof Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. t DiNatural 1 Tyes 2 No 2 Accident 6 Could not be 3 C Suicide 28l. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person - MD 21224 Ball iday view 505 Hopkins 32. Registrar's Signature 31. Date filed (Month, Day, Year) South 2000 Registrar

**ORIGINAL** 

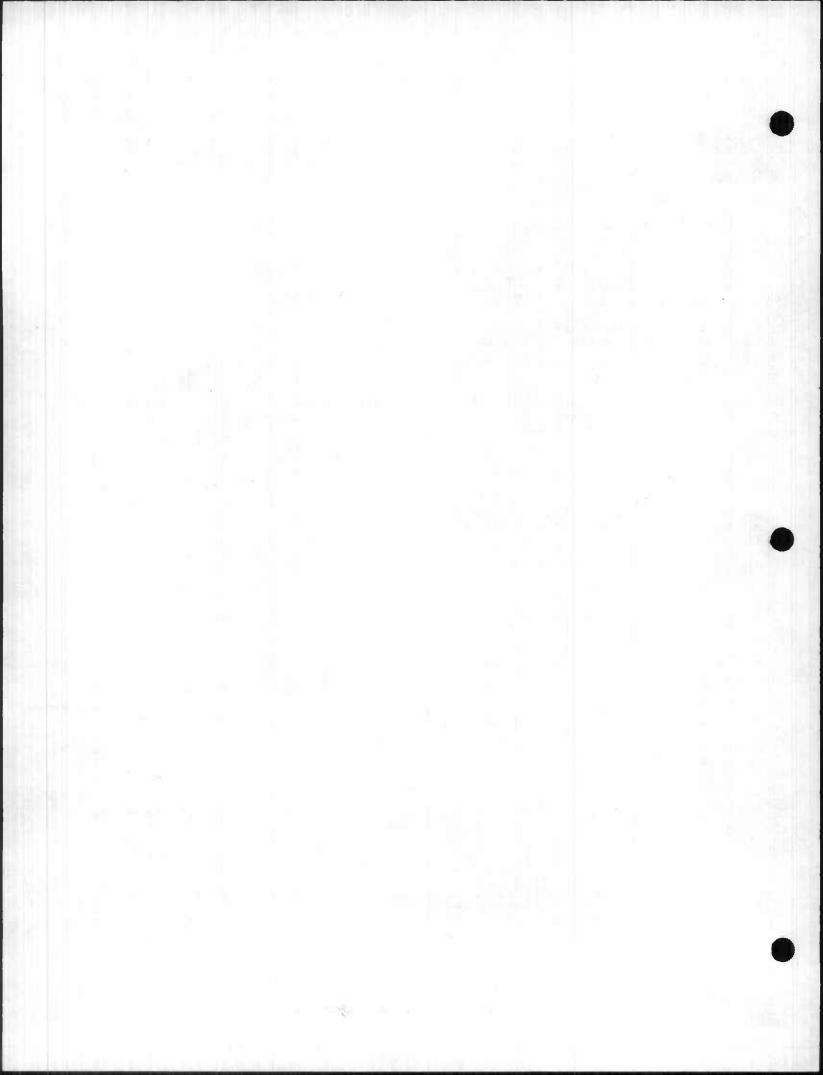


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Marylouise Gilbert Leonard April 2000 12:05AM 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 805 Quincy Road Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2□F 215-34-0834 October 29,1912 | Maryland Director Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or liente 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Towson 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 805 Quincy Road 21286 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 20 No Specify: White Specify: by If Yes, Give Year or Dates: 3XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be in nent of Health end Mentel I with If them 27 is marked of Harry Eugene Gilbert Ruth Louise Kleffman 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e Important: If them 27 is any injury or other tra-Barbara L. Daugherty DTR 8314Carrbridge Circle Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Wurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 4/10/00 Pikesville, Maryland 4 Donation 5 ☐ Other (Som 22. Name and Address of Facility 21. Someture of Funeral Service L Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Part1. Enter the disease, or communations that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finai disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last STENT Box 68760 Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 HMknown Q. Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 Tho 1 TYes 2 No or Attending Physician: 25. Was case reterred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Aftar 5 Pending investigation 1 Netural Hospital or Attending
 24 hours after death.
 Funeral Director: After 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and titie 29c. License number 29d. Date signed (Month, Day, Year) 4-7-00 273 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) TOWSON, MD 21204 M 1) 7601 31. Date filed (Month, Day, Year) 32. Registraf's Signature State

DHMH 16 Rev 6/95

Registrar

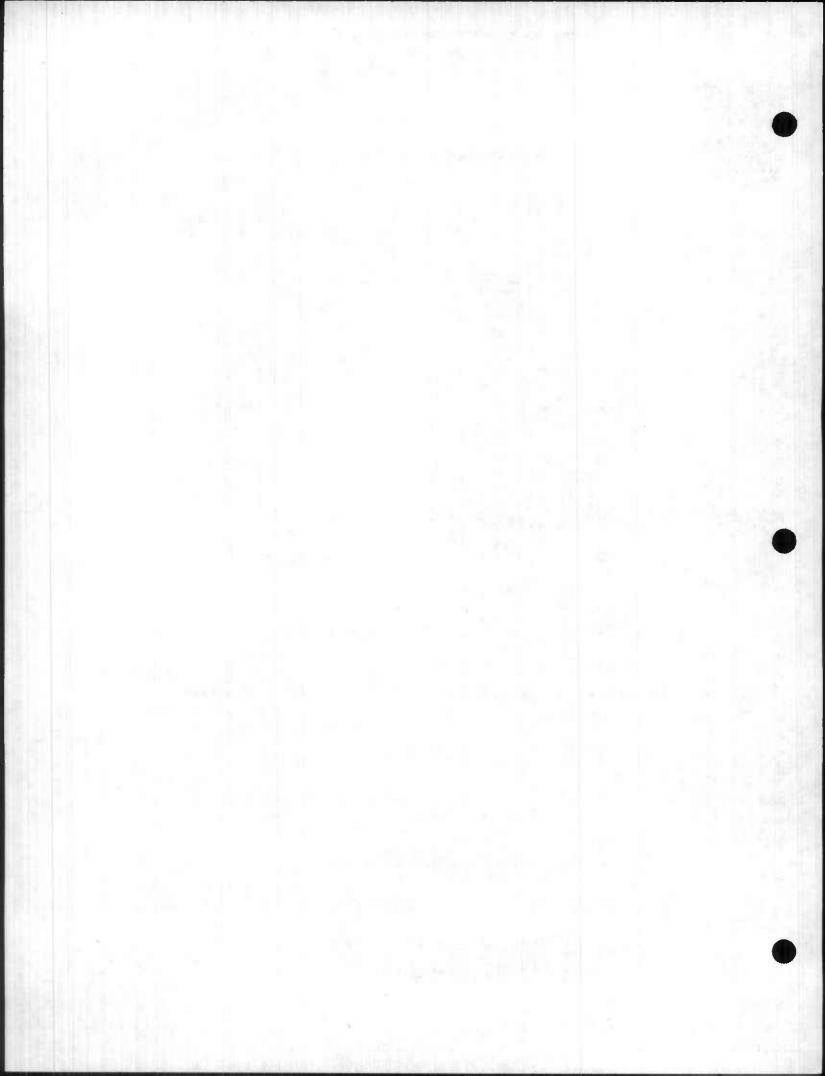


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State of Maryland / Department of Health and Mental Hygiene

	•	-			
of Health and Me	ntal Hygiene	00	18	90	)
of Dooth				-	

1. Decedent's Name (First, Mid	idia, Last)		007	outo o	f Death	2. Date of De	Reg. No.	3. Tie	ma of Death
an Antonio I and						Month	Day	Year	10 A M
Antonio Lanz		horl			4h City Town	APRIL or Location of Death			10 A.M.
4a Facility Name (# not Institut		oer)						•	
St. Agnes H		. Aga (fn yrs.	last hirthday	If Under 1 Ya	Baltin			N/A	tata as Earains
212-34-9571 Usual Residence of Decedent	152 M 2□ F	71	Yrs.	Months Day		Ars. 8. Date of Bir (Month, Da Jan. 1		9. Birthplace (S Country) Italy	late or Poreign
10a. State 10b. Coun	nty	10c. City	y, Town or Loc	cation		100		10d. Insi	ide City Limits
Maryland Bala	timore	F	Raltimo	re High	lande			10	Yes 2 No
10e. Street and Number	CIMOI C		Jarcino	10f. Zip Code			10g. Citizen of	What Country?	
2800 Georgia	Augnio			212					
11. Manital Status	12. Was Deced	lent Evar in U.	.S. 13. W			(Specify Yas or No		ed States	
1 ☐ Never Married 2 ☑ Mil 3 ☐ Widowed 4 ☐ Divorce	arried Armed Ford	as?		Yes, specify Co  ☐ Yas 2 ☐ N		(Specify Yas or No uerto Rican, atc.)	Specia	ock, White, etc.  White	
15. Deced	ent's Education		16a. Deced	ent's Usual Occ	cupation		16b. Kind of E	Business/Industry	
(Specify only high Elementery/Secondery (0-12 12	hast grade completed)  College (1-	4or 5+)		kind of work dor 00 NOT usa ret t Maker	cupation ne during most of ired)	working	Carper	iter	
17. Fathar's Nama (First, Middl	la, Last)		OUDING	C Haitel		Name (First, Middle			
Giovanni Lanz	7.0				Dogá	a Manfusi	1.2		
19a. Informant's Name/Relation			19b. Mailine	a Address (Stra		na Manfred		n, State, Zip Code)	
Antonio Lanzo						Arbutus,			
20e. Method of Disposition	3 (3011)	20b. P	lace of Dispos	sition (Name of		Data Data		- City or Town, Sta	ite
1 Burial 2 ☐ Cremation		tate	emetery, crem	atory or other p	olace)				
4 Donation 5 Other		Mea				k4/15/00			
21. Signature of Funeral Service	ca Licensee	М				mbrose Fu			
Charro	M MM	Jan-		-	-	ng Road A		MD 2122	7
23a. Part1. Enter tha disease, shock, or haart failure. Li  Immediate Causa (Final disease or condition resulting in death)	a.	1000	0	(a) ?	fan	ction			and Death
7	b. H.	. 1	Xià					Da	4
Sequentially fist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	0	1	or as a consequ	uence of):					0
ceuse. Enter Underlying Cause (Disease or Injury	c.   Y	lem						Do	14
resulting in death) Last	1		r as a consequ	uance of):					0 /
Part II. Other significant condi	L d Q	- ++ -	,						
Part II. Other significant condi	Itlons contributing to dea	th but not resu	ulting in the un	derlying cause	given In Part I.	23b. Dld	tobacco use co	ontribute to the ca	use of death
- CA	D					_ 10	Yes 2□No	3 Probably	4 Denknow
- Poe	41'om	W	J.				an autopsy ormed?	24b. Were auto available completio of death?	
						10	Yes all No	1 ☐ Yes	2 No
25. Was case referred to medic	cel				26. Place of	Death (Check only	one)		
axaminar?	Hoenital:	patient 2 3	ER/Outpatient	3 DOA	Other	ng Home 5 ☐ Resi		ther (Specify)	
1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend 2 Accident Inve: 3 Suicida 6 Coul 4 Homicide dete	28a. Date of	Injury	28b. Time of		njury at Vork?		how injury occu		
3 Suicida 6 Coul	stigation	, Day Year)	Injury		☐ Yes 2 ☐ No	28f. Location (	Street and Num	Number or Rural Route Number,	
4 Homicide	building	g, etc. (Specif)	y)			City or To	wn, State)		
	ying Physicien: To the b al Examiner: On the bas and manne	is of axaminat							ruse(s)
	fier n C	\		29c. Lice	ensa number		29d. Data sign	ed (Month, Day, Y	ear)
29b. Signature end title of certif			14 4 1		A				
> Hoham			MN	DI	40610		April		000
29b. Signature end title of certification  Who Sharm  30. Name and address of person  MOHAMMAD				DI			Aprill		229.



Division of Vitai Records, P.O. Box 68760,

	#5 PER G782 4-14-00 WR.	•	Department of Health Certificate of Death		00 11000
	1. Decedent's Name (First, Middle, La	nst)	Continuate of Boath	2. Date of Death	3. Tima of Death
Physician /Medical	Walter W	Dilliam MGS	ley	April 8	2000 4:37F
Examiner	4a Facility Name (If not institution, gir			own, or Location of Death	County of Death
		vare Hospital		edale	Baltimore
Funeral Director	1 212 17 7270	Sex 7. Age (In yrs. lest	birthday) If Under 1 Year If Under 1 Year	24 Hrs. 8. Date of Birth (Month, Day, Yea	9. Birthplaca (State or Foreig Country)
ours after death with the Meryland Tall, or items 23s or 28s-1 show Examiner must be notified at Div Funeral Director	10a. State 10b. County	10c. City, To	own or Location		10d. tnside City Limits 1 ☐ Yes 2 to No.
ifar death with the Me r items 23s or 28s-1s short must be notified. Funeral Director	10e. Street and Number	Truck COV	10f. Zip Code	109. 0	itizen of What Country?
23a c	11540 Philad	elohja Rd.	21162		USA
	11. Merital Stetus	1/2. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Or If Yes, specify Cuben, Mexica	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
72 hours after natural; or he accept to the	3 ⊠Widowed 4 □ Divorced	1 X Yes 2 □ No If Yas, Give Year or Dates:	1 Vas 2 No Specify.		Specify: White
- 1 4 4	15. Decedent's E (Specify only highest gr	ade completed)	Sa. Decedent's Usual Occupation (Giva kind of work done during mos life. DO NOT use retired)	at of working	Kind of Business/Industry
d within plene. r than the the	Elementary/Secondary (0-12)	College (1-4or 5+)	loreman	1000	DEIRTINO
tal Hyg d other event, 1	17. Father's Name (First, Middle, Last	2	18. Moth	er's Name (First, Middle, Maide	n Surnami
Die He	have mas	ley		NORA LOI	191
2 9 4 5	19a. Informant's Name/Relationship	Type (Print)	9b. Mailing Address (Street and Numb	er or Rural Route Number, City	bc/Town, State, Zip Code)
1 and Houth om 27	20a. Method of Disposition	20b. Place	of Disposition (Name of	Date 20c.	Location · City or Town, State
Pages nent of l int: if the iry or a	1 Burial 2 Cremetion 3 4 Donation 5 Other (Specia	Removal from State	itery, crematory or other place)	April 10	and II AA Manda
교원론들.	21. Signature of Funeral Service Lice	TC YUTE	Funcial Chapel - Bold 22. Name and Address of Facility	"Evans Fun	and Chand
Depariment impo	Norda.	(1/1/2000)	sens de ala	1 DD BOOK	ingan MA 2172
	23a. Part1. Enter the disease, or com	pplications that caused the death. D	to not entar tha mode of dying, such as	cardiac or respiratory arrest,	Approximeta Interval Between
Physician					Onset end Death
/Medical Examiner	Immediate Causa (Final disaasa or condition resulting in death)	. Mespir	atory tail	re	
<u> </u>		Due to (or as	a consequence of):		
ansit	Sequentially list conditions	b. De DSIS	a consequence of):		
ian en urial-tri	if any, leading to immediate cause. Enter Underlying	Gastoni		Bleed	
seth certificate be executed ettending physician end for use as the burial-transit clan/Medical Examir	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ding sees		d			
ss that the death certificate be see greed by the ettending physician e be detached for use as the burial- by Physician/Medical Ex	Don'th Other slowliff and an distance			not Didashar	
thet the de ed by the detached	Part II. Other significant conditions (	7/61 1.	in the underlying cause givan in Part	1000	o use contribute to the ceuse of death  2 No 3 Probably 4 Unknown
es the	Chronic C	16Structive	Tulmo Nary Wi	Sease 12	
The law requires that the law has been signed by the page 2 should be detached completed by Physical page 2 should be physical page 2 should be physical page 2 should by Physical page 2 should be page 3 should be 3 should be page 3 should be 3 shoul				24a. Was en aut performed?	available prior to
The law requir					completion of cause of death?
Cor				1 ☐ Yes	2 No 1 Yes 2 No
5 5 0	25. Was case referred to medicat examinar?	Hospital:	_ Other _	e of Death (Check only one)	
certification of Be	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury 28t	o. Time of 28c. Injury et	ursing Home 5 ☐ Residence 28d. Describe how in	
Physician: or this certific eral director, n: To Be (		(Month, Day Year)	tnjury Work?		
To the Hospital or Attending Physician: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	1 ANatural 5 Panding 2 Accident investigatio		M 1   Yes 2	No	

State Registrar

31. Date filed (Month, Day,

Vove

2000

Year)

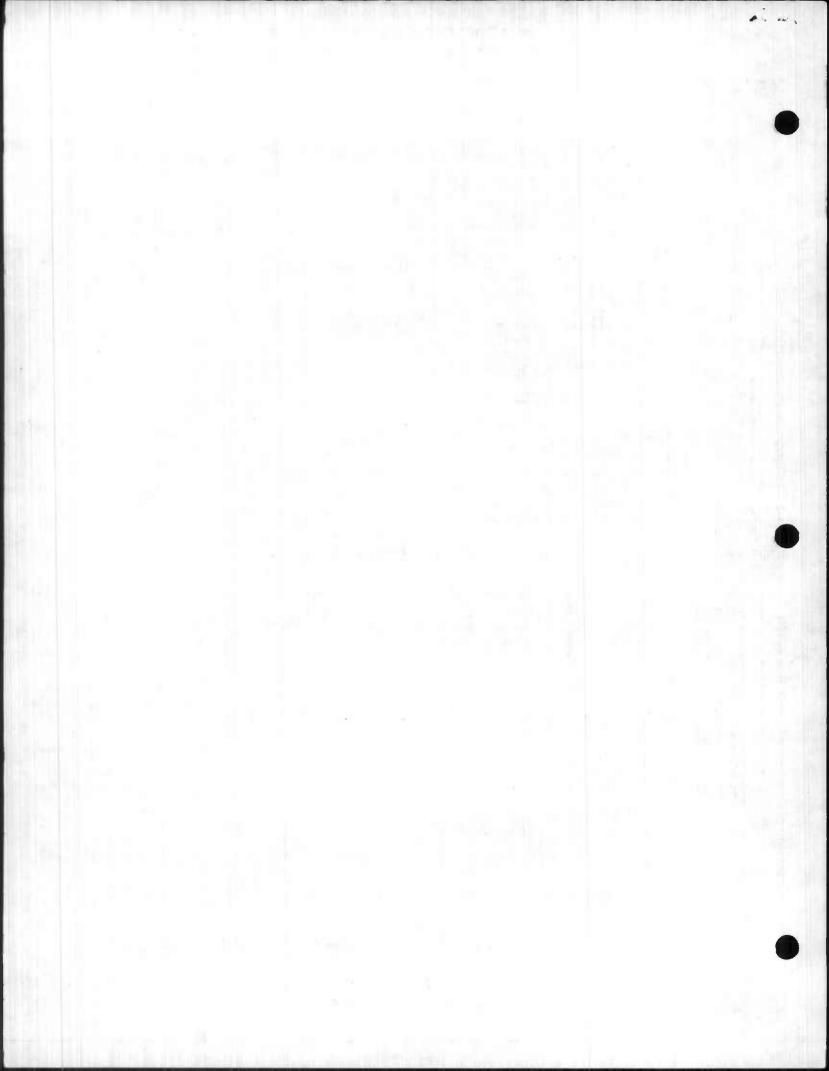
DHMH 16 Rev 6/95

mpleted cause of death (Hem 23a) (Type, Print)

O M.D. 9000 Fgank

32. Registrar's Signature

lin Square Drive, Baltimore Maryland 2/237



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Year Physician Month 8:15 Am miller 4b. City, Town, or Location of Death 2000 aymond 0/ /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Terring thous 21234 Genesis Eldercare md If Under 24 Hrs If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Hours 12 M 2□ F 9 214-03-1673 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f ahow Examiner roust be notified at 1 Yas 2 No Director HIMORD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2613 21234 Funeral deeth Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Wes Decedent Evar in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be flied within 72 hours after nent of Heelth end Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1⊠ Never Married 2 Married Baltimore, Maryland 21215-0020 natural', or Specify: While 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed th end Mentai Hygiene.

?? Is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Controllor Rowan Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be CVa 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Heelth er Important: If Item 27 Ia any Injury or other trau VINSON Wulham olumbia 20b. Place of Disposition (Name of 20a. Method of Disposition April 13 20c. Location - City or Town, State cemetery, crematory or other piece) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Comoter 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Furieral Service Licenses 22. Name and Address of Facility EVOUS FUKERal Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Md 21234 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Paumine Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the Dua to (or as a consequence of) 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? le cultur ulce 1 Yes 2 No 3 ☐ Probably 4 ☐ Winknown signed t Records. þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Be Completed 24a. Wes an autopsy 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Hospital or Attanding Physician: director. 25. Was case referred to medical 26. Placa of Deeth (Check only one) axaminer? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural deeth. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deet To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be 281. Location (Street end Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number unior 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md 21234 401 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar onks

**ORIGINAL** 



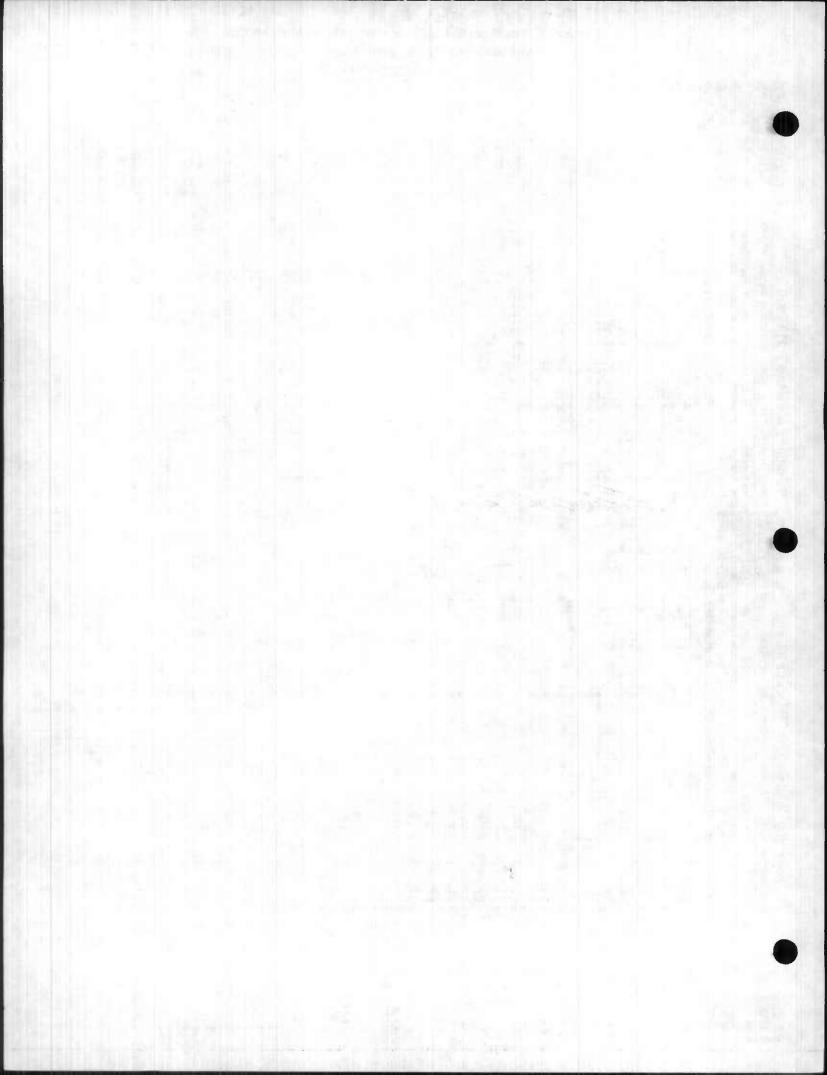
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State of Maryland / Department of Health and Mental Hygiene 00 11902

	1 December 1 Same / First Add											. No.		
	Decedent's Name (First, Middle, Last)										of Death			3. Time of I
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ICI	RIVERVIEW C	ARE	CENT	FR				EC	CEV			DALT	TMOI	DF
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	219-28-1276	10	M XXF		82 Yrs.	Month	ns Days	Hours	Min.		h, Day, Ye			lace (State or
	Usual Residence of Decedent				02					Tourie	29,	1917	MAR	YLAND
	10a. State 10b. Count	ty		10c.	City, Town or I	Location							1	0d. Inside Cit
Director	MD. N	I/A			DALTIM	ODE				1XX es				
	10e, Street and Number	I/A	_		BALTIM		Zi- Codo			10a Citizon			ten of What Country?	
i				10f. Zip Code							109.			Kry r
runer at	602 S. LINWO	OD A					21224					U.S.F		
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l	3 ☐ Widowed 4 ☐ Divorce	ed	Year or D	Give 1 ☐ Yes 2)(No Specify:								Specify	WHI	TE.
	15. Decede (Specify only high	ent's Educ	cation	Con Man	16a. Dec	edent's U	sual Occu	petion	et of work	ina	16	b. Kind of Bu	siness/Inc	dustry
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	5 SELF					F EMP	PLOYE	D			R	ESTAUR	ANT	
	17. Father's Name (First, Middle, Last)								er's Nam	e (First, M		iden Sumem		
								ELT	7/00	TU II	ANNIA	M		
	19a. Informant's Name/Reletion		na Print!		105 14-1	illne Add-	ose /Cha-			TH H		ity or Town,	State 7i-	Codel
	JEAN N. MONTEF	ERRA	NIE/ D	AUGHTE		S. I	LINWO	OD AV	ENUE		IMOR	E, MARY	LAND	21224
	20a. Method of Disposition  1 Derlat 2 Cremation	3 □ □	emovel from		. Place of Disp cametery, cr	remetory of	or other ple	eca)	i	Date	200	c. Location -	City or To	wn, State
	4 Donetion 5 Other (		omover from		EENMOU	NT CE	METE	RY 4	/11/	00	B	ALTIMO	RF M	ARYLAN
	21. Signature of Funeral Service	e License	90				and Addr	ess of Facil	lity				111-311	
	1	-	,1	0	-	FILL	1 & Z	EILER	INC	. FUN	ERAL	HOME		
	- Collection	20	242	an.		1901	EAST	ERN A	VENU	E, BAL	TIMO	RE MAR	YLAN	D 2123
	shock, or heart tailure. List	or compli- st only on	cations that one couse on e	caused the de	eath. Do not e	inter the m	node of dv							
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LAGIIIIICI	disease or condition resulting In death)	<b>1</b>	)	Due to	)eme	equence of	<u>a</u>	ing, such å	s cardiac	or respirati	ory errest		4 1 1	Interval Betwoonset and D
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**ORIGINAL** 

FRANCIS MONTE FERRANTE



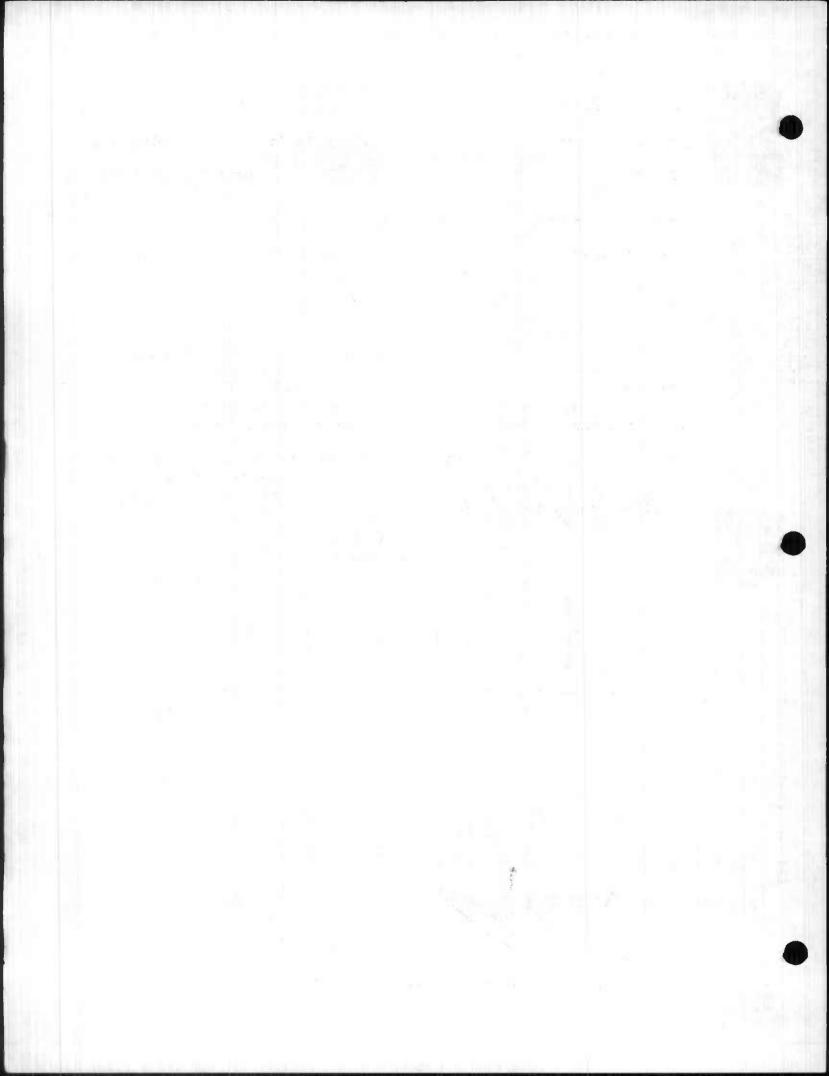
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State of Maryland / Department of Health and Mental Hygiene

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eral ctor		Social Security Nu 217-14-9805		6. Sax 1 □ M 2021 F		e (In yrs. le 79	est birthday Yrs.	) If Undar Months	1 Year Deys		24 Hrs.	8. Date of (Month, January	Birth Dey.	(ear)	9. Birt	hplace (State or Formunity) aryland	
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Medica	30	o. Nama and address							ore.	Marv1	1 (	7		1-11	-0	O	

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

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							0	Death			Reg. No.			
	1. Decedent's Name (First, Middle, Last)									2. Date of De	ath		3. Time of Death	
ian	Mary Loretta McGr	aw							10.7	April April	12, Day	2000 Year	1:00 A.M.	
cal ner	4a Facility Name (If not institut		treet and num	ber)				4b. City, To	wn, or Lo	cation of Deat		ounty of Dea		
61	9502 Powderhorn L	ane						Ralt	imore			Raltim	ore Co.	
	5. Social Security Number	6. Sex	7	. Age (In yrs. las	st birthday)	If Under		If Under	24 Hrs.	8. Date of Bir (Month, Da	th			
	579-05-7864 Usual Residence of Decedent	10	M 20 F	88	Yrs.	Months	Days	Hours	Min.	April 22	, 1911	Wasi	rthplaca (State or Forei ountry) hington, D.C.	
	10a. Stata 10b. Cour	nty		10c. City,	Town or Lo	cation				10d. Inside City Lin				
0.000		timore	co.	Bal	timore	1					1 ☐ Yes			
The second second	10e. Street and Number 9502 Powderhorn L	ane				10f. Zip		I-1022					ountry? s of America	
	11. Marital Status			ent Ever in U,S.	13. \				igin? (Spe	ecify Yes or No Rican, etc.)		Race - Am	erican Indian,	
	1 Never Married 2 M 3 Widowed 4 Divorce		Armed Ford 1 Yes 2 If Yes, Give Year or Dat	- XNo		1 Yes, spec		Specify:		Hican, etc.)		Black, Whi	white	
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-	(Specify only high Elementary/Secondary (0-12	-	College (1~	for 5+)	life. L	kind of wor DO NOT us	e retire	d) mos	e or work!	ny .		Utili:	ties	
	12		n/a			Telepho	one C	nerato	r			(PEP		
-	17. Father's Name (First, Midd	le, Last)					and and			(First, Middle	, Maiden Su			
0	Hubert Mark Foley							Viole	+ 1	Simpson				
	19a. Informant's Name/Relation		oe, Print)		19b. Mailin	ng Address	(Street			al Route Numb	er. City or 7	own. State	Zio Code)	
	Ms. Mary Loretta			m)						,Marylan		234-151		
	20a. Method of Disposition	ricui aw	Nuaugrite		9 DIU			Dail	more	Date			Town, State	
ı	1 Ø Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		emoval from Si	ate	netery, cren r Hill	Cemete	ther place erv		4/	15/2000	Suitla	ind Mar	vland	
	21. Signature of Funeral Service	J. Licenses	Geffre	y L. Gair	22	. Name and	d Addre	ss of Facili	<sup>19</sup> Ruck 1050	Towson York Rd	Funeral Tows	Home,	Inc. 21204-2515	
	23a. Part   Emer the disease, shock, or heart failure. L	or compile	ations that car	used the death.	Do not ente	er the mode	e of dyir	ng, such as				701131 123	Approximate	
ı	shock, or heart failure. L	int only/gine	a cause on ea										Onset and Death	
	Immediate Cause (Final			Co	· N	10		1					(3	
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edical Examiner	Cause (Disease or injust	c.		Due to (or a	s a consequ	uence of):							12902	
	that initiated events resulting in death) Last	L,												
	that initiated events resulting in death) Last	d.	ributing to dea	th but not resulti	ng in the ur	nderlying ca	ause giv	en in Part	l.	23b. Dld	tobacco us	e contribut	i to the cause of deat	
	resulting in death) Last	tions control	0	th but not resulti	1		ause giv	ren in Part	I.	-	tobacco us	1	in to the cause of deat	
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	resulting in death) Last	d.	0	0	1		ause giv	en in Part		1 a 24a. Was perfe	Yae 27	3 F	Probably 4 Unknown Were eutopsy findings available prior to completion of cause of death?	
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epartment of Health and Mental Hygiene	00	11905	
Certificate of Death			

Physician							tificate d		r	eg. No.			
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/Medical Examiner	An Pla		DORE	ive street and nun	n <i>ber)</i>	MA	LLINO		Location of Death	4c. County		13:45	p.m
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Important: If item 27 any injury or other ti		Method of Dis	position Cremation 3 [ 5 Other (Spec	Removal from s	State Ba	Place of Dispo cemetery, crem ltimore	sition (Name on atory or other Washi	ngton Crei	Date 14-11-00	20c. Location - Laurel,	City or Tow Mary	vn, State	
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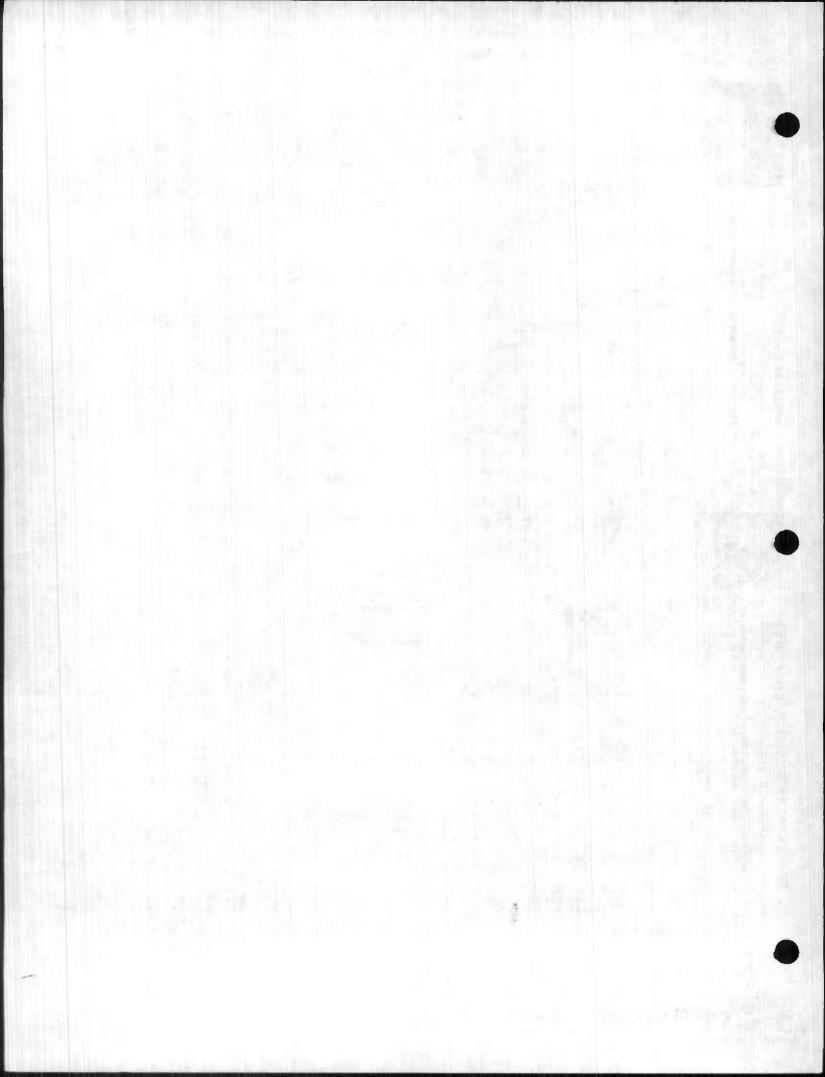
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95
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State of Maryland / Department of Health and Mental Hygiene

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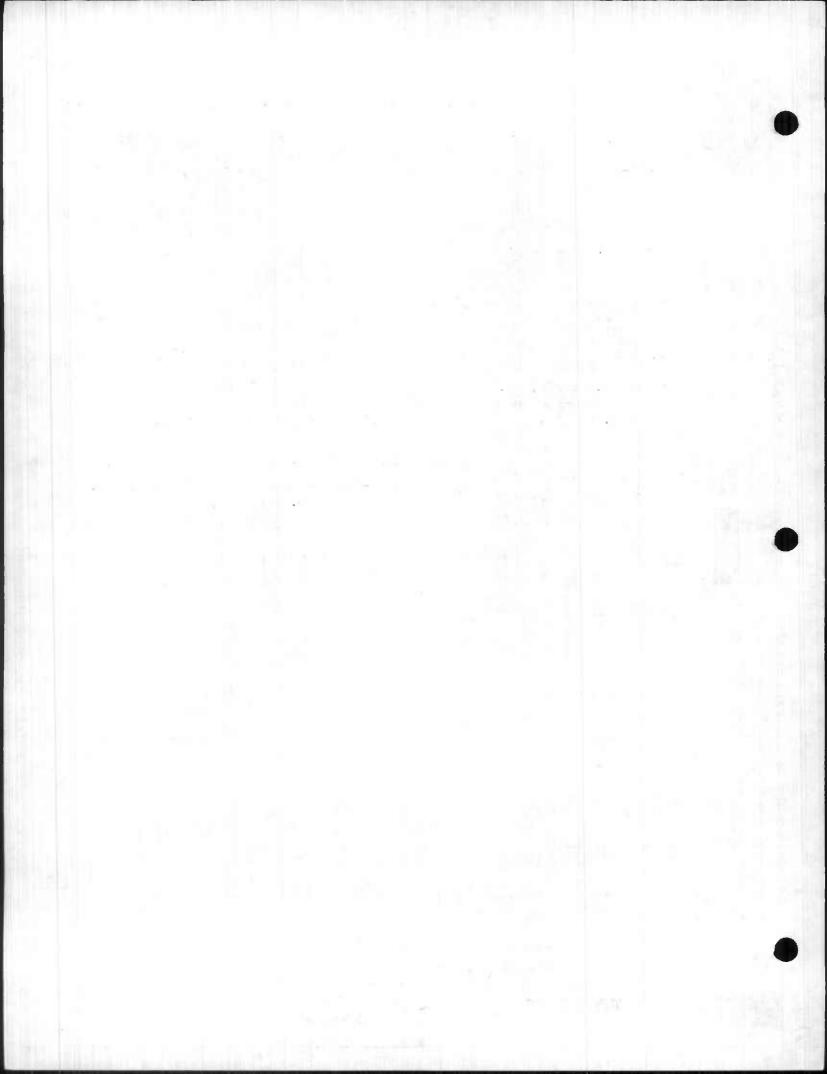
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	Examiner	4e Facility Neme (If not Institution	n, give street and nu	umber)				, or Location of Deat	h 4c. County	of Death	
		UNIVERSITY HO  5. Social Security Number	SPITAL 8. Sex	7. Age (In yrs.	last birtho	(ev) If Under 1 Ye		MORE CITY Hrs. 8 Dete of Bir	th	9 Birtholece	e (State or Foreign
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	ath with the Merylar 23s or 28s-f show unit be notified at ral Director	2603 FARMOUNT AL	JE.			21223	3 .	1	IL S.A.		
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Box 68/60,	at the death certificate be executed by the attending physician end etached for use as the bunial-transit.  Physician/Medical Examin	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ASSOC c			sequence of): NIC INTRAVE sequence of):	INOUS DRUG	ABUSE		1	
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<u>a</u>	entifica ctor, p	25. Was case referred to medicel examiner?						f Deeth (Check only	one)		762 802-000
2	Physician: The law this certificate has al director, page 2 TO Be Comp	XYes 2□ No				tient 3 DOA		ing Home 5□ Res			
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	To the Mospital or within 24 hours after To the Funeral Director completely filled in Medical Cert	29a. Certifier 1 Certifyin (Check only one) Medical	Examiner: On the I	e best of my kno basis of exemine nner steted.	wledge, d	eeth occurred et the r investigation, in m	e time, date end p by opinion, deeth	plece, end due to the occurred et the time	cause(s) end ma , date end piece,	and due to th	id. e ceuse(s)
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		30. Name and address of person	11 .								
	State	31. Deterfiled (Month, Dev., Year)	TESTEN 32.	Registrer's Signa	atura			, Marylan	d 21201		
	State Registrar	31. Deterfiled (Month Dev. Year) APR 12	2000	seneva	1	. Soon	61				

15.2.

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a Eacility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year 9. Birthplace (State or Foreign Country) yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2XF 215 - 01 - 2000 Usual Residence of Decedent Yrs. Director with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits Show le marked other than "naturel", or items 23s or 28s-f show sumstic event, the Medical Examinal must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a and Injury or other traumatic event, the Medical Examinations. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1□Yes 2 No Specify: whish Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education ify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stale 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) COM. 2000 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NEUMONIA Examiner Due to (or as a consequence of): Physician/Medical Examiner MENTIA attending physician and for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 5 thknown of Vital Records, by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of tnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of codilie 2000

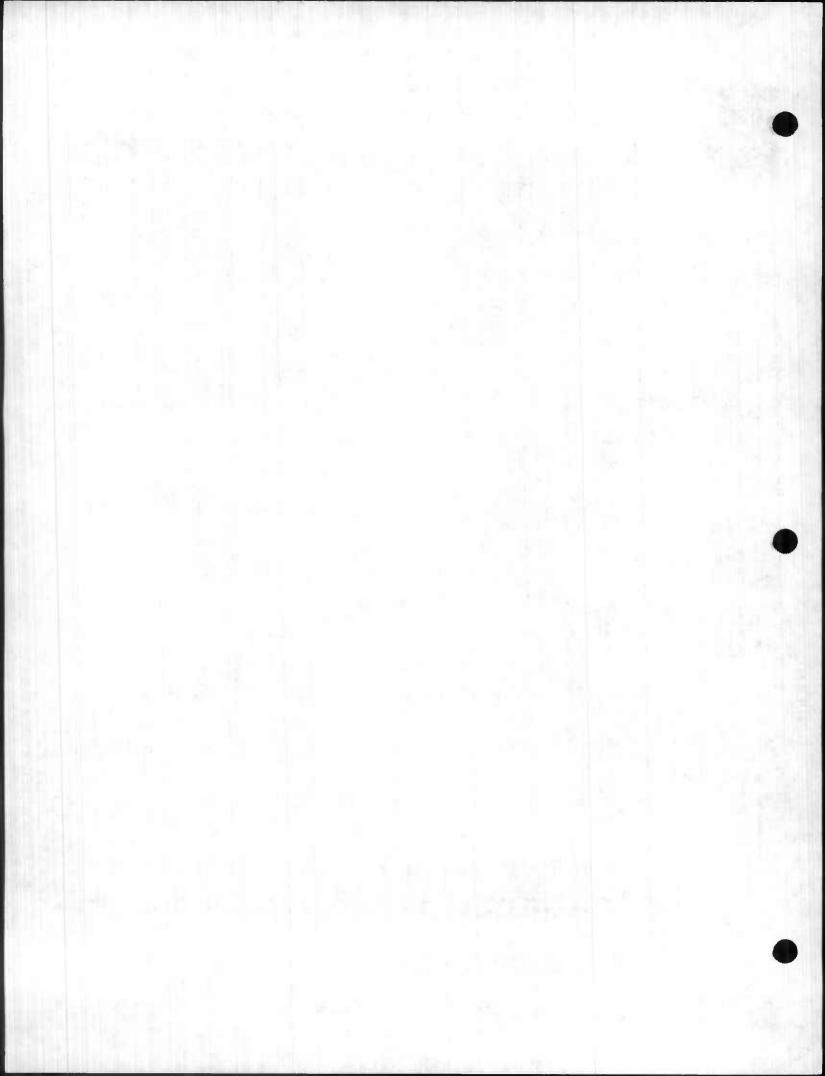
Registrar

State

31. Date filed (Mon!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

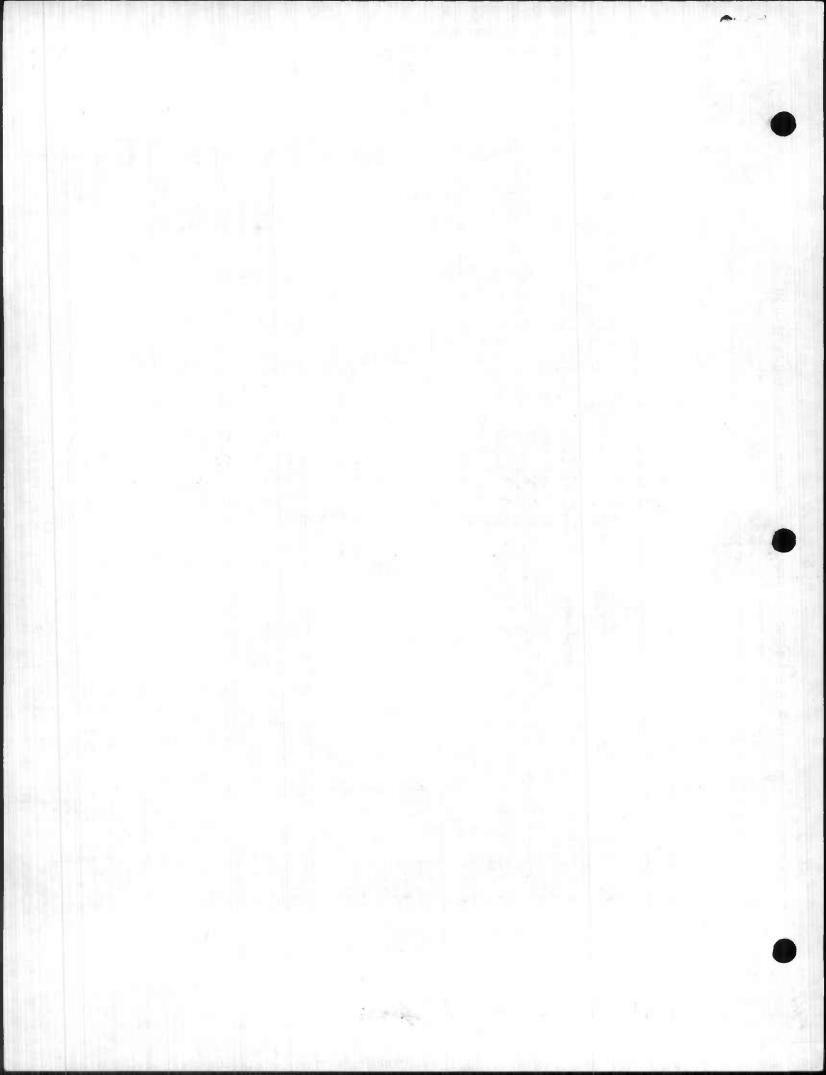


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State of Maryland / Department of Health and Mental Hygiene

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10s. State 10b. County 10c. 6	City, Town or Location				10d. Inside City Limits
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11. Meritel Status 12. Wes Decedent Ever in	U,S. 13. Was Decedent of	Hispanic Origin? (Specify	y Yas or No-	14. Race - A	merican Indian,
1 Nevar Married ZXXMerried 3 Widowed 4 Divorced Year or Dates:			an, etc.)	Specify:	White White
15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Occ (Give kind of work don	upation e during most of working	16b	. Kind of Busine	ss/Industry
Elementary/Secondary (0-12) College (1-4or 5+)		<del>0</del> 0)		Dun Homo	
	HOHEIRKE	18. Mother's Name (F.			
Herbert Oscar Howard					
19a. Informant's Neme/Reletionship (Type, Print) Mr. Charles Edward Nolan / husband	19b. Mailing Address (Street 111 Dublin Drive	et and Number of Bural R	Oute Number, Ci	ity or Town, State	e, Zip Code)
1 Burial 2 Cremetion 3 Removel from Stete	cemetery, cremetory or other pi	lece)	Dete 20c	. Location - City	
			12/2000	I imonium,	, Maryland
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23a. Pert1. Enter the diseasa, or complications that caused the de shock, or heart feilure. List only one cause on each line.					Approximate Interval Between
•					Onset and Death
Immediate Cause (Final disease or condition BreAs	t Cancer				12 years
resuming in death)					
b					1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disagre or Injury)	(or as e consequence of):				
	(or as e consequence of):	14			
d					
Part II. Other significant conditions contributing to death but not re	asulting in the underlying cause of	given in Pert I.		1 -	ute to the cause of death?  Probably 4 Unknown
			1 108	40 NO 3	3. Toolog 4 Onknown
		Milia.	24a. Wes an a		b. Were eutopsy findings available prior to completion of cause of death?
			1□ Yes	22(No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Death //			
examiner?	□ ER/Outpatient 3□ DOA	ther		e 6 DOther (S	Specify) (+ a spice
27. Manner of Death 1 → Natural 5 → Pending 28a. Dete of Injury (Month, Day Year)	28b. Time of 28c. Inj	ury at 28d ork?			The spice
3 Suicide 6 Could not be determined 28e. Place of Injury - At		281.			Rural Route Number,
(Check only 2 Medical Examiner: On the basis of examiner					
A A	29c. Lice	nse number	29d.	Date signed (M	onth, Day, Year)
DAAM 110.					The state of the s
Thomas long, he	y y	3000	M	11/	-000
30. Name and address of person who completed cause of death (III	em 23a) (Type, Print)	l. 56	600.	to mo	(21208
W.A. Kiley Oppil	6701 M. Chr		1200	101 /110	9
	Security Number   214-22-2496	Social Security Number   214-22-2496   Sax   1 M 2XD   7. Age (in yrs. liast birthday)   If Under 1 Yas   124-22-2496   Months   Day   D	5. Social Security Number 214-72-2496  214-72-2495  10	S. Scial Security Number  214-22-2496  Daus Residence of Decedent  10s. Street and Number  10s. Street and Number  110. Contry  MD  Baltimore  Lutherville  10s. Street and Number  11. Medital Status  11. West Decedent Ever in U.S.  12. West Decedent Ever in U.S.  13. Was Decedent of Helpanic Origin? (Specify Yes or No-  11. West Decedent Ever in U.S.  13. Was Decedent of Helpanic Origin? (Specify Yes or No-  11. West Decedent Ever in U.S.  11. West Decedent Ever in U.S.  12. West Decedent Ever in U.S.  13. Was Decedent of Helpanic Origin? (Specify Yes or No-  11. West Decedent Ever in U.S.  12. West Decedent Ever in U.S.  13. Was Decedent of Helpanic Origin? (Specify Yes or No-  11. West Press people) Cubers, Medice, Resil  13. Was Decedent of Helpanic Origin? (Specify Yes or No-  11. West Press people) Cubers, Medice, Resil  14. Resident Specific Specify  15. Decedent's Specific Specify  16. Decedent's Specific Specify  17. Feither's Name (First, Medice, Lesi)  18. Mother's Name (First, Medice, Lesi)  19. Melling Address (Street and Number of Biograf Sperip Number, Co.  19. Melling Address (Street and Number) Design (Sperip Number, Co.  19. Melling Address (Street and Number) Design (Sperip Number, Co.  19. Melling Address of Facility  19. Melling Address (Street and Number) Design (Sperip Number, Co.  19. Melling Address of Facility  19. Melling Address of Facility  19. Melling Address of Facility  19. Melling Address of Sperip Decedent Specific Number of Helpanic Design (Sperip Number, Co.  19. Design (Sperip)  19. Design (Sperip	Social Source Number  214-22-2496  Usual Residence of Decedent  106. Cety  107. Cety  107. Cety  108. Cety  109. Cety  1

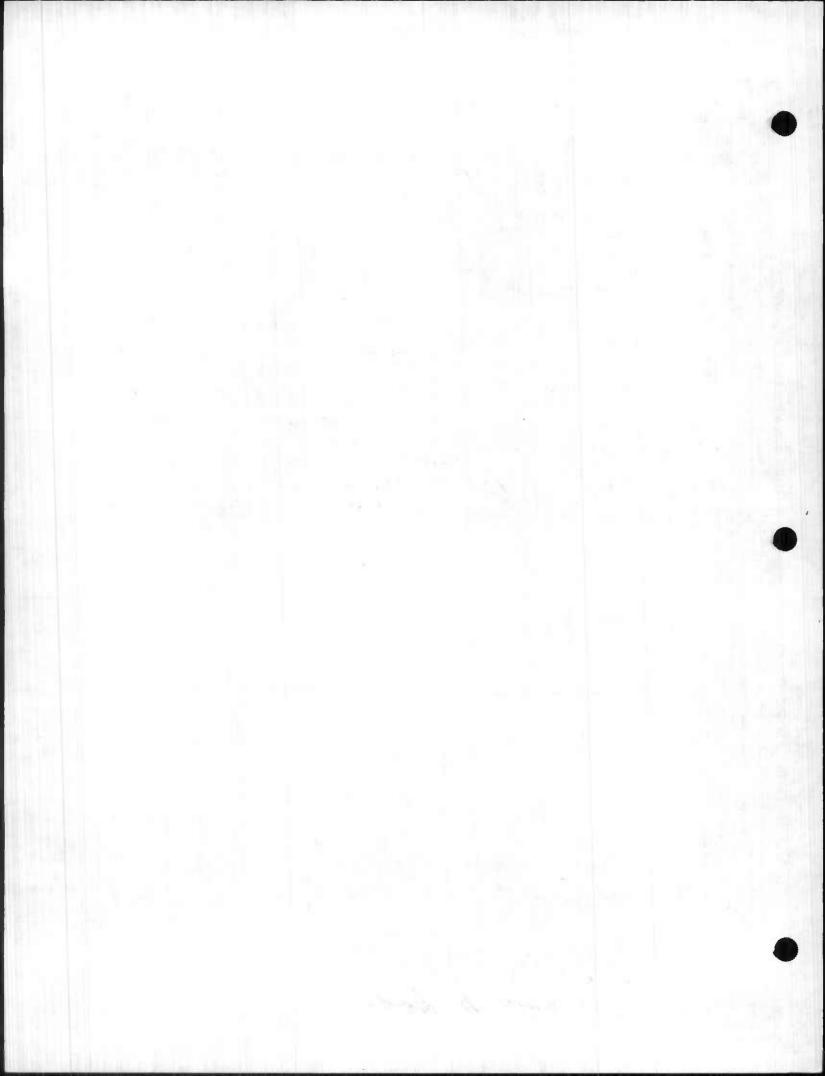


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State of Maryland / Department of Health and Mental Hygiene

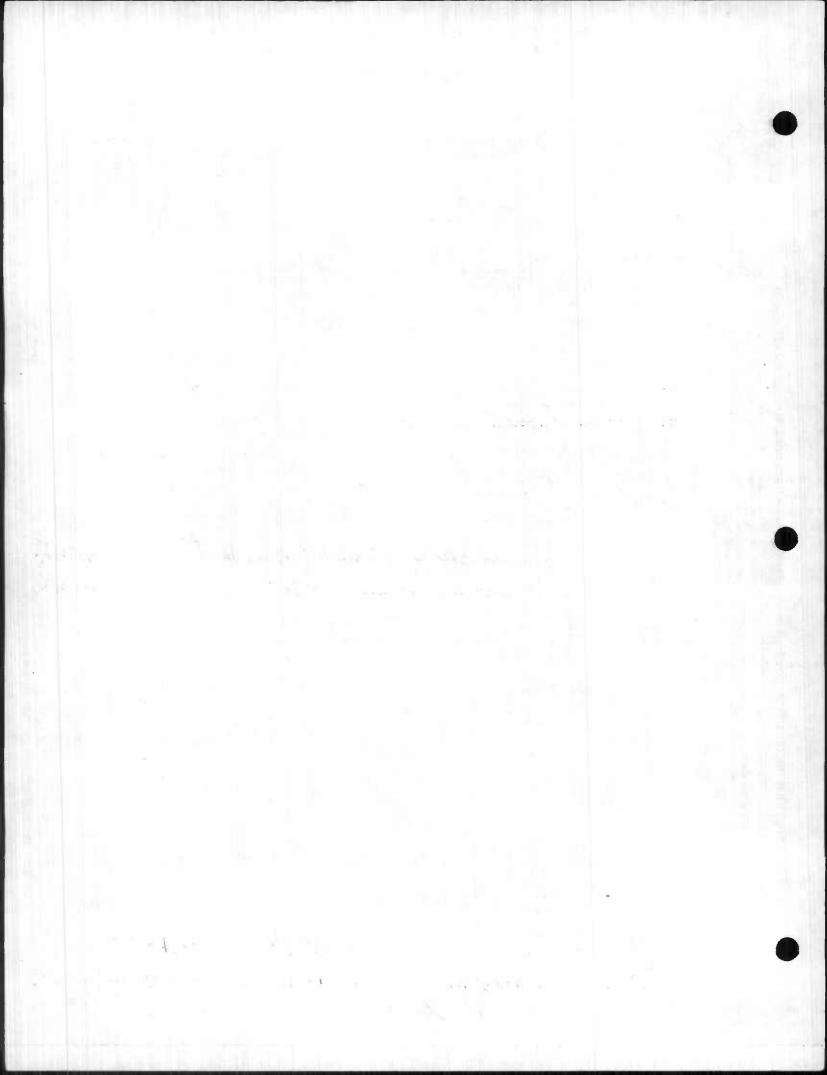
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/Medical Examiner	4e Facility Neme (If not institution, g	ive street and numb	ber)				4b. City, To	wn, or Lo	ocation of Death	4c. County		1.0	I van
	8702 Downey Roa	d					Se	vern		Anne	Arur	ndel	
Funeral	Sociel Security Number 6.		. Age (In yrs. la	st birthday)	If Under				8. Date of Birth	Variab	9. Birthp	place (Stete	or Foreig
Director	407-58-2039 Usual Residence of Decedent	1□ M 21XF	71	Yrs.	Months	Days	Hours	Min.	(Month, Day, Oct. 11	,1928	Gern		
nours arrar deam with the marylend hurel; or fleme 23s or 28s-f show at Examiner must be notified at bd by Funeral Director	10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Înside (	City Limita
to or	MD Anne A	rundel	Sev	vern								1 ☐ Ye	s ZIZN
be notified be notified Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?	
3a O	8702 Downey Roa	đ				21	144			USA			
ritems 23s or 28s-f showning an ordinad at Funeral Director	11. Meritel Status	12. Wes Deced		. 13.1	Was Dece			igin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac		can Indien,	
by F	1 Nevar Married 2XMMarried 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	₩No		lf Yes, spe 1□ Yes				Rican, etc.)	Specif	ck, White, y: V	etc. Vhite	
ygiene. Ner than "naturel; It, fre Medical Ex-	15. Decedent's (Specify only highest g			16a. Deced	dent's Usus	al Occu	petion	et of work	ina	16b. Kind of B	usiness/In	dustry	
than 'n than 'n main and	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. I	DO NOT u	se retire	during mos	H OF WORK	""9				
giene.	8			Но	memal	ker				Own	Home		
T 20 6	17. Fathar's Nema (First, Middle, Las	st)					18. Moth	er's Name	e (First, Middle, A	Maiden Sumen	ne)		
2 0 m	Fredrich Steinm	etz					Em	ma U	nknown				
th end Mental It 7 is marked of treumatic eve	19a. Informant's Neme/Reletionship	(Type, Print)		19b. Mailir	ng Address	(Stree	t and Numb	er or Run	al Route Number	City or Town	Stere, Zip	Code)	
Department of Heelth e Important: if fem 27 is any injury or other trei ance.	Roy D. Nelson (	Husband)							ern, MD				
E et	20a. Method of Disposition	FILE	20b. Pla	ce of Dispo	sition (Na	ne of		1		20c. Location	City or To	own, State	
T N	1XXBurial 2 Cremetion 3		919	netery, cren				i	04/13				
and a	4 Donetion 5 Other (Special Signature of Eugeral Service Lice	•	mary	land			ess of Facili	h.	2000	rownsv	ille,	MD	
any i	17/1	6 11	//	-	Harde	esty	Fune	ral	Home, P.	Α.			
	Hardesty Funeral Home, P.A.  12 Ridgely Avenue, Annapolis, MD 21401												
	23a. Part 1. Enter the disease, or con shock, or heart failure. List onl	y one cause on eed	sed the death. th line.	Do not ent	er the mod	le of dyi	ing, such as	cardiac i	or respiratory arm	est,		Approximately and the consett	neewie
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Medical aminer	Immediata Causa (Finel diseese or condition		f	encu	satic		can	er			1	8 mor	NB
	resulting in death)			as a conseq							1		
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g physician and es tha bunel-transit Medical Examir	Sequentially list conditions,	0.	Due to (or a	as a conseq	uence of):								
uniel uniel	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury												
hysic that the that the that the that the the the the the the the the the th	that initiated events resulting in death) Last	C	Due to (or a	as a conseq	uence of):								
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the a	Part II. Other aignificant conditiona	contributing to deat	h but not result	ing in the u	nderlying c	ause gi	ven in Pert l	l.	23b. Did tobacco use contribute to the cause of				of death
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age 2									1 □ Ye	s 2DNo		Yes 2	T No
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s certificate he director, page To Be Com	25. Wes case referred to medical axaminer?	Hospitel:				. O	her		h (Check only on				
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al Director: After the date of in by the funeral Certification:	Netural 5 Pending	28a. Dete of (Month,	Day Year)	lojury		&c. Inju			28d. Describe ho	w many occur	100		
the f	2 Accident investigeting 3 Suicide 6 Could not	he			М		Yes 2						
Director: In by the ertifical	4 Homicide determine	289. Place of	Injury - At hom, etc. (Specify)	ne, farm, str	eet, factory	y, office				cation (Street and Number or Rurel Route Number, y or Town, Stete)			
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To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1		hysician: To the be miner: On the basi end manner	s of examinatio										(s)
To the Funeral completely fille	29b. Signature and title of certifier				290	. Licen:	se number		2	9d. Date signe	d (Month,	Dey, Year)	
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/\	n. well	way fr	ryricia	4		167	117		7	1.401			
m	30. Nema and address of person who		or death (Item 2	23a) (Type, 1		pag 1	er.	, 1	- D	4044	1 -	2 2 1 .	
1		iell JHA	TUMC	779	40	IZA	1/21-	NV	R BAUT.	I MO PR N	nd 21	114	
State	31 Date filed (Month, Day Year)	Sere 32 Reg	istrare cignatu	2000	6				*				
Registrar	1 1 2 2000 /		/										



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	Decedent's Name (First, Middla,	Last)		Cert	ificate of	Death	2. Date of D		Verr	3. Tima of Deat
an cal	Helen	Nicholas					April	10	Year 2000	11:06 p
ner	4a Facility Nama (If not institution, g	giva street and number	r)			4b. City, Town,	or Location of Dea	ath 4c. County	y of Death	
	Heritage Harbor	Health &	Rehab:			Annapo1			e Aru	nde1
	5. Social Security Number 217-58-2188	5. Sex 1 □ M 2 🔀 F	oga (In yrs. le 71		Months Day		lin. (Month, L	Sirth (Pay, Year) 3 , 1928	9. Birthpl Count	**
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7	10e. Stete 10b. County			Town or Loca					10	Od. Inside City Lin
Director		runde1	Ann	napolis				40- 02:	140	**
	10e. Street and Number				10f. Zip Code			10g. Citizen of	Winat Couri	lry r
	35 North Glen A	12. Wes Deceden	t Ever in U.S	. 13. Wa		401 Hispanic Origin?	(Specify Yes or h	USA lo- 14. Rac	ce - America	an Indian.
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	15. Decedent's	Education		16a. Deceder	nt's Usual Occ	upation		16b. Kind of B	usinass/Ind	ustry
	(Specify only highest ( Elementary/Secondary (0-12)	grada completed) College (1-4ol	5+)	(Giva kii lifa, DC	nd of work don NOT use retir	e during most of red)	working			
	12			Owner/	Operato	or		Restau	rant	
	17. Father's Name (First, Middle, La					18. Mothar's	Nama (First, Midd	le, Maidan Sumar	na)	
	Leonidas Milona						sti Chry			
	19a. Informant's Name/Ralationship						Rural Route Num			Code)
	Anna Marriott ( 20a. Mathod of Disposition	Daughter)	20h Ple	/24 R		Street	, Annapo	Lis, MD		en Ctata
	1208. Mathod of Disposition 3	Removal from State	B. CO	matary, crema	tory or other p		04/14			
	4 Donation 5 Other (Spe		St.			emetery	2000	Annapo	lis,	MD
	21. Signatura of Eunaral Sarvice Lic	book	11		Hardest	_	al Home, nue, Ann		MD 01	401
	Immediata Causa (Final disease or condition rasulting In death)  Sequentially list conditions, if any, leading to immediate causa. Entar Undarhying Cause (Disease or injury that Initiated events rasulting in death) Lost	b. Chi	Dua to (or Dua to (or	as a conseque as a conseque as a conseque	ence of):	failes	cciden	<i>C</i>		Monsh
		d	but not rasul	ting in the und	erlyling causa (	given in Part I.		d tobacco use co	-	the cause of de
	Part II. Other significant conditions						11			
	Part II. Other eignificant conditions							as an autopsy formed?	ava	ilable prior to
	Part II. Other significant conditions						24a. Wa	as an autopsy	ava cor of c	ilable prior to appletion of cause
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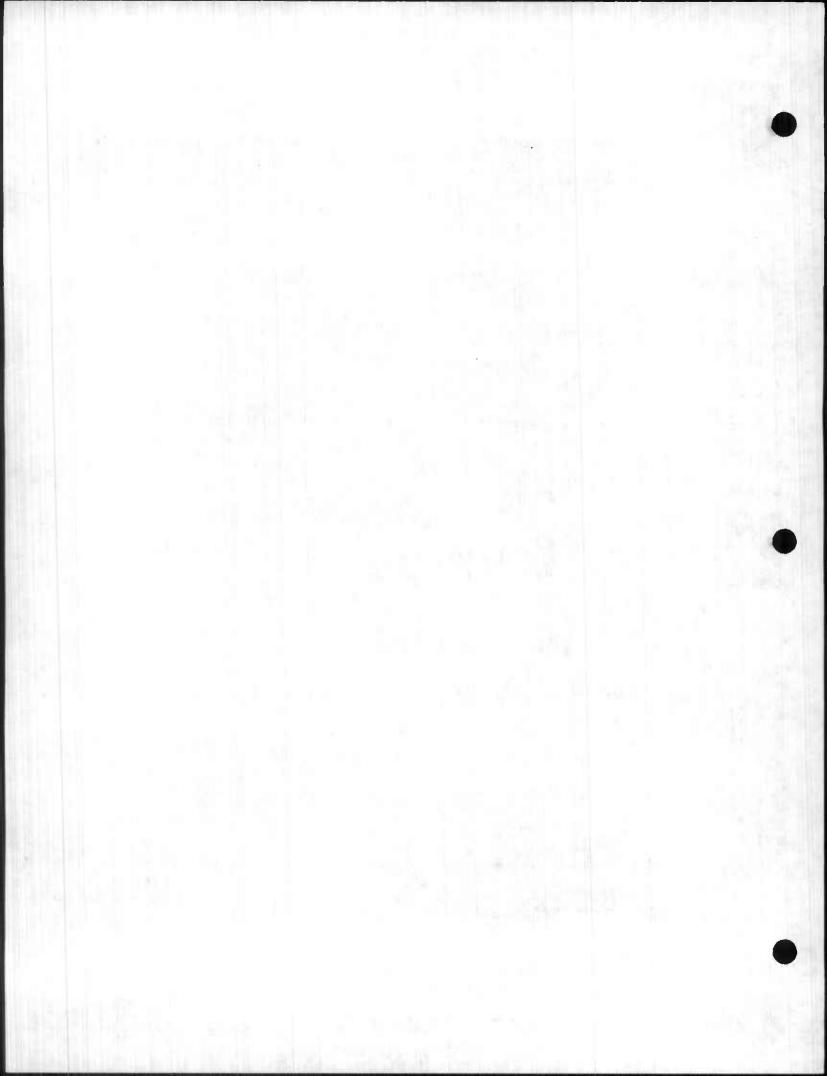


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e of Maryland / Department of Health and Mental Hygiene	00	119	ı
Certificate of Death Reg. No.	00	113	il i

				Certific	ate of	Death		Reg. No.	3 0	11914
Physician	1. Decedent's Neme (First, Middle, L						2. Date of De Month	Day	Year	3. Time of Death
/Medical	Marian L. Petzi	a					April 7	-		9:10 PM
Examiner	4e Facility Name (If not institution, g	the state of the s					or Location of Deat			
	11 Silver Mapl					Balti			timore	
Funeral Director	5. Social Security Number 6.  212-28-1282  Usual Residence of Decedent	Sex 7. Age (	'In yrs. lust bi		ths Days		n. 8. Dete of Bir (Month, Di August	5, 1913	9. Birthpla Countr	ce (State or Foreig <b>Land</b>
8 m	10a. State 10b. County	1	Oc. City, Tov	vn or Location					100	d. Inside City Limit
to fee	Maryland Baltim	oho	Ralt	imore						1 ☐ Yes 2 X No
be notified Director	10e. Street and Number	0.20			. Zip Code			10g. Citizen of	What Countr	y?
	11 Silver Maple	Court			21220			u.	S.A.	
iner mat iner mat Funeral	11. Maritel Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Was D	ecedent of	Hispenic Origin? ban, Mexicen, Pur	(Specify Yes or No		ce - American	
by Etc.	1 Never Merried 2 Married 3 Wildowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Dates:			es 2 No		orto nicari, etc.)	Specify		
ygiene. we than "natum it, the Medical Completed	15. Decedent'a E		16a	. Decedent's	Usual Occu	pation	nding	16b. Kind of B	usiness/Indu	istry
wed ald	(Specify only highest gi	College (1-4or 5+)		life. DO NO	T use retire	during most of w	rorking	5.75		
that no	8th Grade			Seamst	ress			Cloth		
event Be (	17. Father'a Name (First, Middle, Las						leme (First, Middle		ne)	
To To	Marion Lepkows	ki				Josep	hine Lub	inski		
27 is ma or traums	19e. Informant's Neme/Relationship Sandy Shank	(Type, Print) (daughter)		b. Meiling Add	ress (Stree	aple Cou	Rural Route Numb	imore Mi	State, Zip C	Ode)
at of He if them or offer	20a. Method of Disposition 1   Burial 2 □ Cremation 3			ot Disposition ery, crematory			Date	20c. Location		
tant tant dury	4 Donetlon 5 Other (Spec	*	cresi	lawn C		_	4/10/00			ce, mu
Depart import any it	21. Signeture of Funerel Service Lice	ensee Welley					Baltimo L Home.		1236	
1000	23e. Pert1. Enter the disease, or con shock, or heart failure. List only		e deeth. Do	not enter the	mode of dy	ing, such as cerd	iac or respiratory	rrest,	1 7	Approximete ntervel Between
nysician	Grook, of House tallaro. Else of h	y one oddoo on odon into.								Onset and Death
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ician and burial-transit ai Examiner	Sequentially list conditions,			consequence	of):				1	
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ysi ys	Part It. Other significant conditions	confributing to death but i	not resulting	in the underlyi	ing ceuse g	iven in Part I.				the cause of death
detac detac							1	Yas 2∐ No	3 Probe	ably 4 Unknow
sata has been signed to page 2 should be delt							24e Wei	en autopsy	24b. Wer	e autopsy findings
shoul ete							perf	ormed?	avei	lable prior to
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Page Co.		5 4					1 🗆	Yes 2 X No	1 🗆	Yes 2□ No
s certificata has director, page 2 To Be Comp	25. Wes case referred to medical examiner?	Handhali.			10		eeth (Check only	one)		
H H	1 ☐ Yes 2 No	Hospitel: 1 Inpatient			I DOA		Home 5□ Res			
ther the uners	27. Menner of Death 1 De Naturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Y		Time of Injury	28c. Inju		28d. Describe	how injury occur	rred	
or: A	2 ☐ Accident investigation	he		М		]Yes 2□No				
irect n by	3 Suicide 6 Could not determined	28e. Pleca of Injury building, etc. (	- At home, f. 'Specify)	arm, street, fe	ctory, office		281. Location City or To	(Street and Num own, State)	ber or Rural	Route Number,
G 6 6										
within 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral Medical Certification:	(Check only 2 Madical Exa	hyalcian: To the best of r iminer: On the basis of e	caminetion ar	e, death occur nd/or investiga	rred et the tation, in my	time, date end ple opinion, deeth oc	ca, and due to the curred at the time	cause(s) and m , date and place,	enner as sta and due to	ited. the ceuse(s)
thin 2 the 1 mplet	one)	and manner stefe	d.		00- 11			20d D-4i	1 (March 17	less Venel
T CO T	29b. Signeture and title of certifier	6.			29C. Licer	nse number	The second	29d. Date signe	Month, D	ay, rear)
7	Highen D. O	mildans				H40583	3	4/8	100	
2	30. Neme end address of person who	completed ceuse of dea	th (Item 23e)	(Type, Print)	Stephe	G. Smalda	200			
0	2021 B FM	11tun Rd. J	4114	Bel	Air 1	41 21	015			
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signeture	,						
Registrar	APR 1 2 2000	Beneva	9	Ana v	/					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:15 AM 2000 Angela Denise Powell /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number, **Examiner** BALTIMORE BALTIMORE SIMAL HOSPITAL OF If Under 1 Year Birthplace (State or Foreign Country) 5. Scolel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) Months 1 M 2 K F Days Hours Min 214-54-2760 Yrs. 8-14-1949 Md Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland net of Health and Mental Hyglene.
Intil if Item 27 is marked other than "natural", or items 23a or 28a-f show any or other transmit or event, the leadest Ensigher from the round and any or other transmits event, the leadest Ensigher from the round and 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits YYes 2 No N/A Baltimore Director Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S U A 21207 Funeral 3813 Parkview Avenue 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2 W No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 □ Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Post Office College (1-4or 5+) Elementary/Secondary (0-12) Processor 12th grade N/A 18 Mother's Name (First Middle Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Ruth Smith Leroy Taft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Baltimore, Md 21207 3813 Parkview Avenue Leslie Powell- Husband 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o XXBurial 2 Cremation 3 Removal from State 4-13-00 Randallstown, Md 4 Deflation 5 Other (Specify) King Memorial Park 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility March F/H West Some Inmper 4300 21215 Wabash Avenue Baltimore, Md I ter the disease, or complications that caused the death. Do not enter the mode of dylng, such es cardiec or respiretory errest, o heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** mutastatic breast cancer /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examine RESPIRATION 2° to meningeal Physician/Medical Examiner The law requires that the death certificate be executed physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Division of Vital Records. P.O. Box 68760. Due to (or as a consequence of) 88 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Nonknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? bluods Completed s certificate has I 1□Yes X No 20 No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Netural 2 Accident 5 Pending 1 Yes 2 No death. investigation after death Director: A in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medical 29e. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of confifier 4000

ed cause of death (Item 23a) (Type, Print)

(1)

32. Registrer's Signeture

Aly

POWEIL, ANGELA

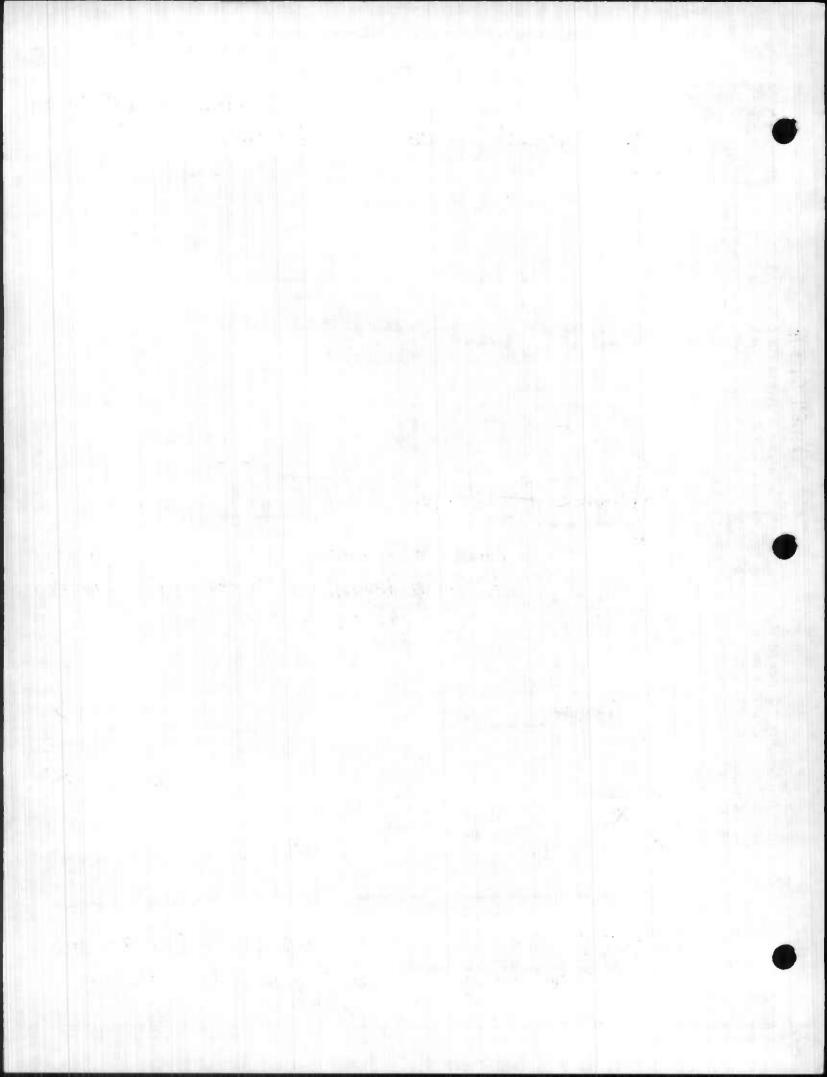
DHMH 16 Rev 6/95

State

Registrar

30. Name and add

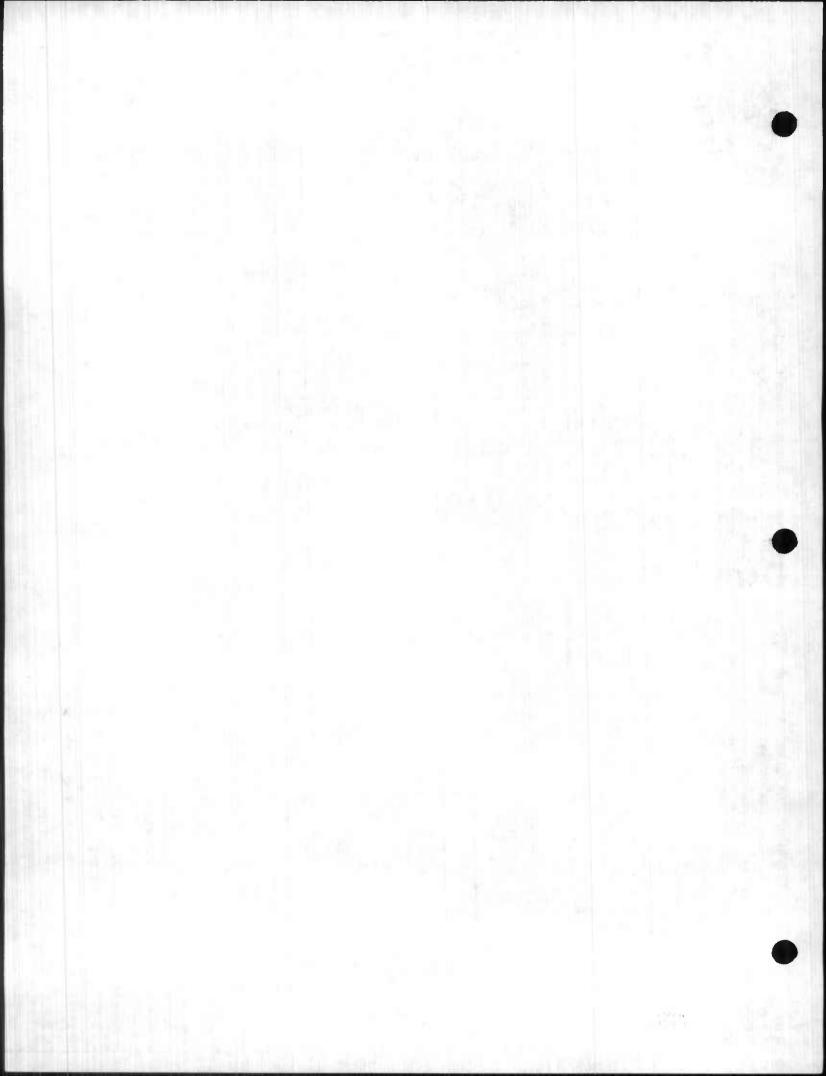
31. Date filed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene 0 0 1 9 16

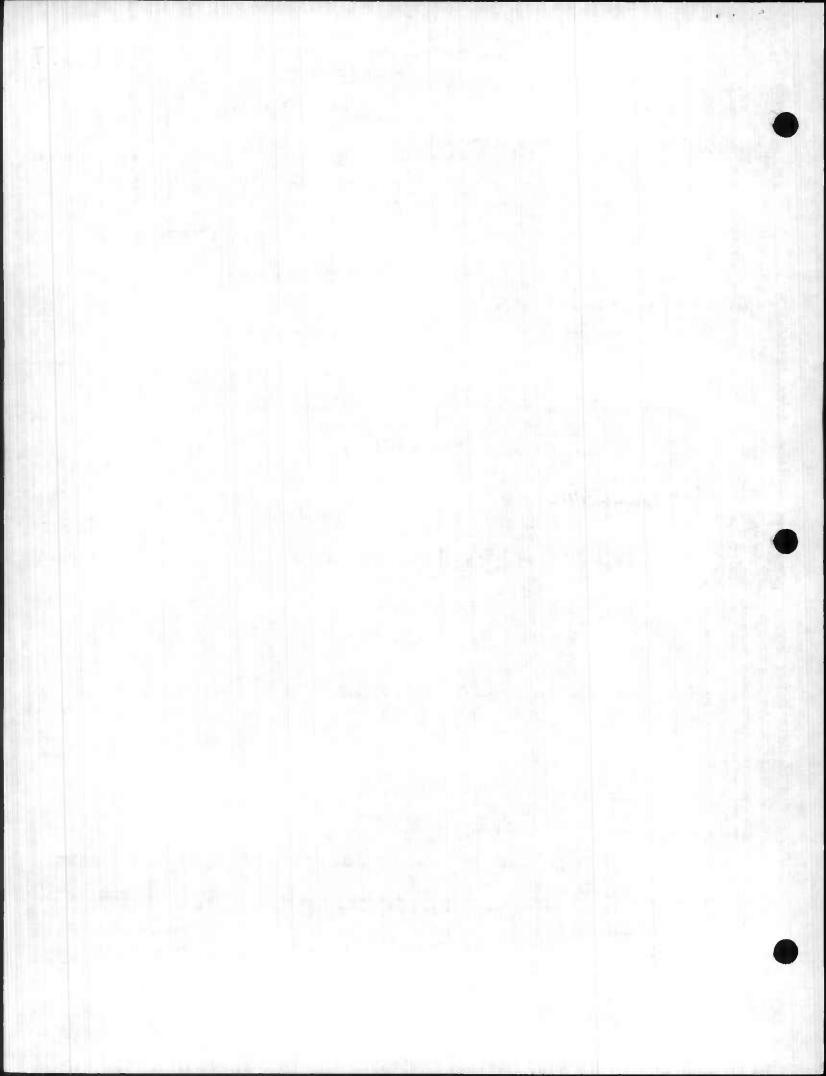
						Cer	tificat	e of	Death			Reg. No.			F
مورد	Physician	1. Decedent's Neme (First, Midd Vastupal Par		110			191				2. Date of Dec		2000	3. Time of Dec 1:51	
	/Medical Examiner	4a Facility Neme (If not institution	on, give street	and number)	4			4	lb. City, To	wn, or Le	ocation of Deeth	4c. Cour	nty of Death		
		Bowie Health	Center	r					Boy	wie		Р	rince	George'	e
	Funeral	5. Social Security Number	6. Sex		e (In yrs. lasi		If Under Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h	9. Birthp	placa (State or Fo	oreign
	Director	136-56-9323	32X M	201	3	Yrs.					08-02		In	idia	
3	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. Count	v		10c. City, T	own or Loc	cation						1	10d. tnside City L	imits
													1 □ Yes 2 □		
		100. Street and Number 101. Zip Code 20720									10g. Citizen of What Country?  India				
020		11. Meritel Status  1 Never Merried 2 164  3 Widowed 4 Divorce	rried 1	res Decedent I med Forces? Yes XXX Yes, Give eer or Detes:			Was Decedent of Hispanic Origin? (Specify Yes or IYes, specify Cuben, Mexican, Puerto Rican, etc.) I □ Yes 2 → No Specify:					or No- 14. Race - American Indian, Black, White, etc.  Specity: Asian			
5			nt's Education	tion 16a Decedent's Usual Occup					ation			Indian 16b. Kind of Business/Industry			
2		(Specify only high	est grade com	de completed)			(Give kind of work done during most of working life. DO NOT use retired)								
7	om it is	Elementary/Secondary (0-12)		College (1-4or 5+) 5+			Scientist 18. Mother's N				Nuclea	ar Phy	sics		
2	d other	17. Father's Name (First, Middle	, Last)						18. Mothe	B. Mother's Name (First, Middle,					
<u>a</u>	Mente de To E	Rasiklal Par:	ikh	Manek Parikh											
a	and A	19a. Informant's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Fi							er or Rur	Rural Route Number, City or Town, State, Zip Code)					
	27 le	Shyam Parikh	Total Sound Roday Bowl						wie, MD 20720						
more	ayes to ent of He	1 Burial 2 Accemation 3 Removal from State Ballelinore Washington 04/9/00 Laur									el, Maryland				
	manual a	21. Signature & Funeral Service Incenses 22. Name and Address of Facility													
ñ	ISE S	Schlanger Mg20 Fleck Funeral Home Inc. 7601 Sandy Spring Road Laurel, MD 20707													
F	10000	23a. Part / Enter the disease, of shook or heart failure. Lie	Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate shock, or heart failure. List only one cause on each line.									Approximate Interval Between	en		
₽	hysician	Onset and Death													
		Immediate Causa (Final disease or condition ACUTE MUSICAR DIR / INFARCTION. 4708													
	RESULTS.	resulting in death)	resulting in death)												
7	in in	Due to (or as a consequence of):  b. ATHEROSCLERATIC HEART DISEASE. 4-10-80  Sequentially list conditions.  Due to (or as a consequence of):										0			
9	and trans														
ָרָ בְּ	olan a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury													
0	the the dica	thet initieted events resulting in death) Last		1	Due to (or as	a consequ	uenca of):							7.	
Y 1	ding i		d										i		
0 5	itend or us														
	the a the shed f	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Dld 1	Did tobacco use contributa to the cause of death				
- 4	detac		1   Yaa 2   No  24a. Was an autopsy performed?								3 Pro	bably 4 Uni	known		
S S	signe d be d										24a Was	a. Was an autopsy 24b. Were autopsy tin			linas
5	shoul shoul										med?	av	ailable prior to empletion of caus		
	has the mpl											of	death?		
											10	res 200 No	1[	☐ Yes 2 No	)
V 185	Be Be	25. Was case referred to medic examiner?	Hospit	al·				Oth		of Deal	th (Check only o	ne)			
	2	172 Yes 2 No		1 LI Inpatie		/Outpatien		PA	4LINI	irsing Ho	ome 5 ☐ Resident			(y)	
ם פו	Ion:	27. Manner of Death  1. ENatural 5 Pend	ing	a. Data of Injur (Month, Da)	Year) 28	b. Time of Injury		8c. Injur Wor		No	280. Describe i	now injury occ	urred		
Marylis of Vital records, F.C. box 60700, and the Hospital or Attending Physician and Attending Physician and Marylis of the time of the structure of Hospital Discourt After this certificate has been signed by the attending physician and Discourt After this certification, page 2 should be detached for use as the bunial-fransit or other traumatic and the physician After the page 2 should be detached for use as the bunial-fransit or other traumatic and the physician After the physici	the the	2 Accident inves	tigation		411		М		Yes 2	NO	not I coation /	Ctoopt on d Ale	mharas Dun	al Route Number	
	in by		mined 28	e. Place of Inju- building, etc	o. (Specify)	e, farm, stre	eet, factor	/, offica			City or Tox	vn, State)	inber or nura	n rioute ivuniber	r,
1	C dilled	29a. Certifier SC Certify	na Physiolen	. To the best o	d mu knoudo	dae deeth	annurend	at the tie	no data an	d place	and due to the	cauca(s) and	mannar a.r.	etated	
2	Fun etely		f Examiner: C		examination						red at the time,				
-	Me the	29b. Signature and title of cartifi					290	. Licens	e number			29d. Date sig	ned (Month,	Day, Year)	
	- 3 - 8		men	· MO			+	00	1366	8		4	-8-0	D	
					noth floor of	(a) /Tunn		00	000	0		, -	0-0		
	Q	30. Name and address of person P2HER HUSS A			T EA	Car (Type, I	1000	RI	) C	110	ege pk	MD.	20740		
	State	31. Date filed (Month, Day, Year			ar's Signature	BI	1000	, -1			pr	1371	-0170		
	Registrar	APR 1 2 7 INIII	Depo	W	12	Boar	Ks								



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				Ce	ertificate of		F	leg. No.	0 119	1 ,/		
ACCOUNT OF THE PARTY OF THE PAR	Physician	1. Decedent's Name (First, Middle, L PATRICIA M	TTS	2. Date of Dea Month	Dey	Year 2000 1:15						
	/Medical Examiner	4a Facility Name (If not institution, g			10 6 19	4b. City, Town, or Lo	cation of Death	of Death TIMORE				
	Funeral		PKINS HO	Age (In yrs. last birthdey  67 Yrs.	) If Under 1 Year Months Deys		8. Date of Birth	Year)	9. Birthplace (State of Country)	or Foreign		
	Director	Usual Residence of Decedent		07			October	22 1932	Australia			
1215-0020 within 72 hours after death with the Marylan and ene. Than 'vestures', or thems 23a or 25a-f show the Medical Examiner must be notified at	in-t show titled at ctor	Florida Okaloos	a	Destin	ocation				10d. Inside Cl 1 ∑ Yes			
	ath with the Ma 23s or 25s-fs sust be notified rai Director	10e. Street and Number 280 Gulf Shores			10f. Zip Code 32541			Austral	Citizen of What Country?			
	by B	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 A If Yes, Give Year or Dates	No	U.S. 13. Was Decedent of Hispanic Origin? (Si ff Yes, specify Cuban, Mexican, Puerlu 1 ☐ Yes 2 ☒ No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of work the DO NOT use retired)  Homemaker		ecify Yes or No- Rican, etc.)	14. Raci Blac Specify	e - American Indian, k, White, etc.			
		15. Decedent's (Specify only highest g Elementery/Secondary (0-12)		(Giv life.			16b. Kind of Busin Own Home					
d 2	Lai Hygi d other avent, I	17. Father's Neme (First, Middle, Las	it)	Home	18. Mother's Nem							
ylar	Menta Menta mkad mbad To B	Leo Joseph Kenny		•		Patricia	Edith	Stewart				
Mar	2 sh and lam	19a. Informant's Name/Relationship				and Number or Run						
	Health Health Hear 23 dhair 1	Leo J. Potts, M.	D. (Hus	sband) 280	position (Neme of		Dest11		Lda 32541. City or Town, State			
timor	P # 2	1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec	ity)	Green Mo	ount Crema	atory 4	-8-00		re, Maryla	nd		
Ba	Dapa Impo amy is amy is	21. Signature of Funeral Service Lice  Steven T. Puttle	•		6500 York	Wiedefeld Road Bai	ltimore	, Maryla	Inc. and 21212			
10		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	ed the death. Do not en line.	nter the mode of dyi	ng, such es cardiec	or respiratory ar	rest,	Approximet Interval Bet Onset and I	ween		
	Physician /Medical Examiner	trimediate Cause (Final disease or condition resulting in deeth)	a. MET.	A STATIC  Due to (or as e conse		GEAL	CANC	ER	3460	irs		
,0,	cate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):									
		that initiated events resulting in death) Last	c	Due to (or as e consequence of):								
B.	to the deam cert dby the attending selected for use Physician/M	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause gi	23b. Did 1	obacco uss co	ntributs to the cause	of death?			
s, P.C	es that the or igned by the be detached by Physic					10	Yes 2□No	3 Probably 4 X	Unknown			
ecord	A 40 00						24a. Was perfo	en autopsy med?	24b. Were autopsy to available prior to completion of confideath?	to		
R	ate ha						101	es 2 No	1 □ Yes 2 2	No		
Vita	entific ector.	25. Was case referred to medical examiner?	Heavital			28. Place of Deat	h (Check only o	ne)				
of Vital Records, P.O. Box 68760, mystclen: The law requires that the death certificate be executed mystclen: The law requires that the death certificate be executed mystclen: The law requires that the death certificate be executed mystclen.	S S P	1 Yes 2 No 27. Manner of Death	Hospital: 1 Minpa		ent 3LI DOA			lence 6 Oth		0		
sion	can be attended by a state of attended by the funerial by the funerial Certification:	1 Netural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, E	lnjury	M 1	rk? ] Yes 2 □ No		cribe how Injury occurred		phor		
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	in 24 hours he Funera pletely fille			t of my knowledge, dea of examination and/or i steted.						\$)		
	Within To the To	29b. Signature and title of certifier	- 1		29c. Licens				d (Month, Dey, Year)	16.		
		Helle	8 CL M			414 735	1	APRIL	6,2000			
1	Do	30. Name and address of person who HENRY TAN, 60	O NORTH	WOLFE STR		TIMORE,	MARYL	AND 2	1287			
	State Registrar	31. Date filed (Month, Day, Year) APR 1 2		trar's Signeture	5 Apo	uks			- /61			

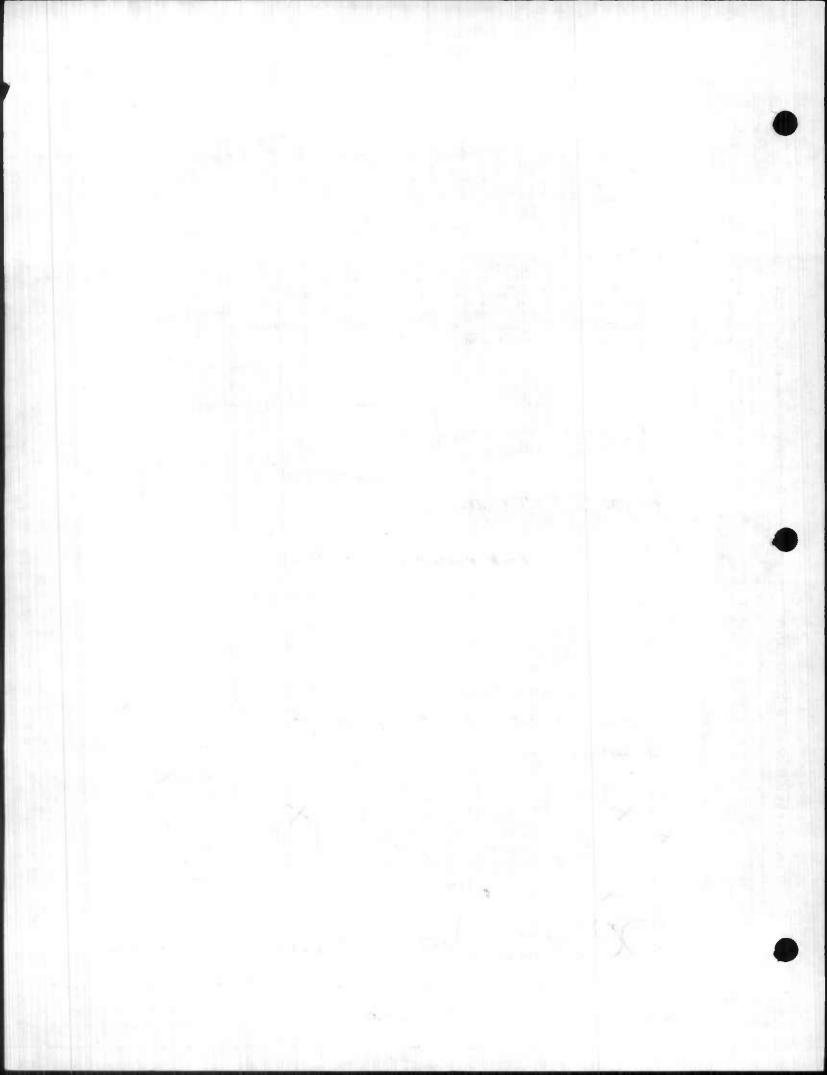
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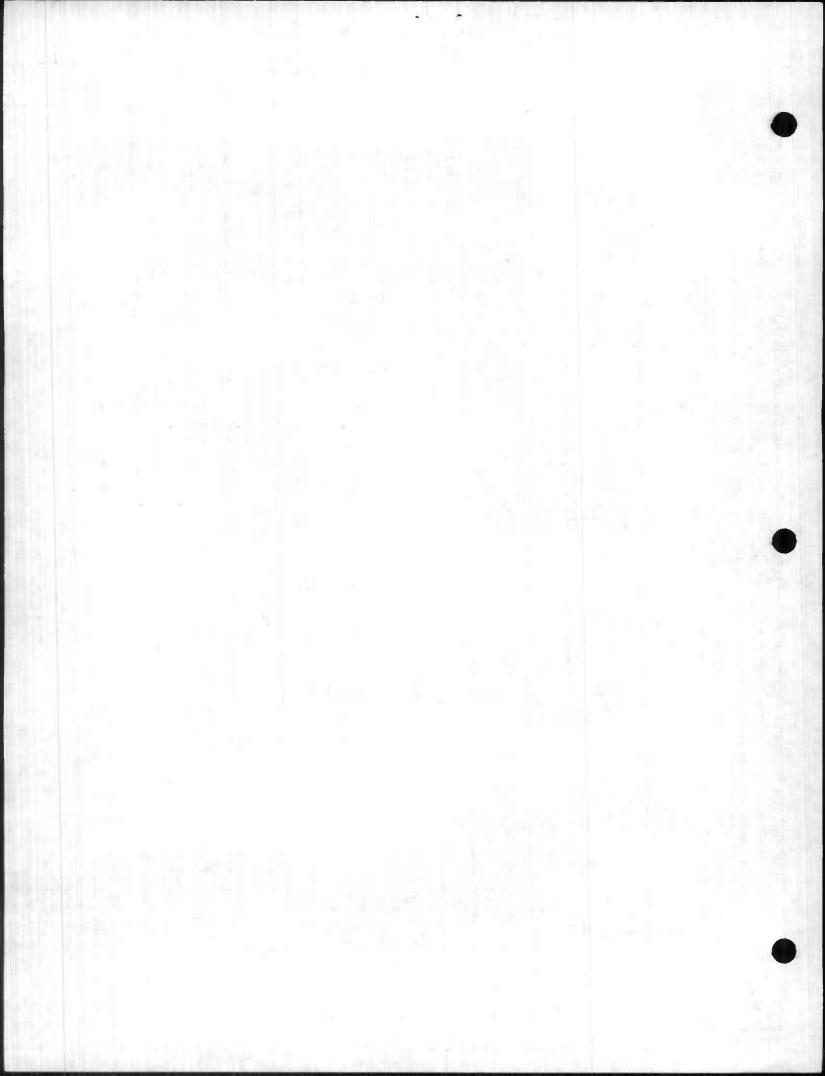
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** James Thomas Pointer 08, 2000 April 6:15am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rock Glenn Nursing Home Baltimore Birthplaca (State or Foreign Country) If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 67 Yrs. 5. Social Security Number Data of Birth (Month, Day, Year) **Funeral** Days Hours 1QM 20F Months 231-36-2158 Director 06-27-32 VA Usual Residence of Decedent the Maryland 10a. Stata 10b County 10c. City. Town or Location 10d. Inside City Limits ns 23s or 28s-f show must be notified at MD x1 Yas 2 □ No NA Baltimore Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2124 W. Fayette Street 21223 flems 23s USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 2 No if Yes, Giva Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0020 natural, or 1 Yes 26 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 7 Hyglens. other then 'n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importants if hem 27 is marked other the any Injury or other traumatic Truck Driver 7th Grade Regional Management 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) 86 Roland Pointer Gee-Dale Poteat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Lorraine Pointer 2124 W. Fayette Street Baltimore, MD. 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from Stale Innation 5 Other (Specify) Woodlawn Cemetery 04-13-2000 Woodlawn, MD re of Funaral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a Print1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on which ine. Approximate Intervat Between Onset and Death **Physician** Ininediata Cause (Final disease or condition resulting in death) /Medical 0 myorandial a Merk Examiner Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): US0 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No Congresse of Goot, Dicker, peripheral signed b by 24b. Were autopsy lindings available prior to 24a. Was an autopsy Completed vaceula disrese COFA completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital a Hospital or Attending Physician: 24 hours after death. a Funeral Director: After this certificate in by the funeral director; 25. Was case referred to medical examiner?
1 Yas 2 No Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yas 2 ☐ No investigation 114 NIT 2 Accident NIA 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide NA \*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical To the Hosp within 24 hor To the Fune completely fi miner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and time of pertifier 29c. License number 29d. Data signed (Month, Day, Year) 1)43386 4-10.00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Bulkinore mo R. Itoward 2 Exter 31. Data filed (Month, Day, Year) 32. Registrar's Signatura APR 1 2 2000 oaks Registrar

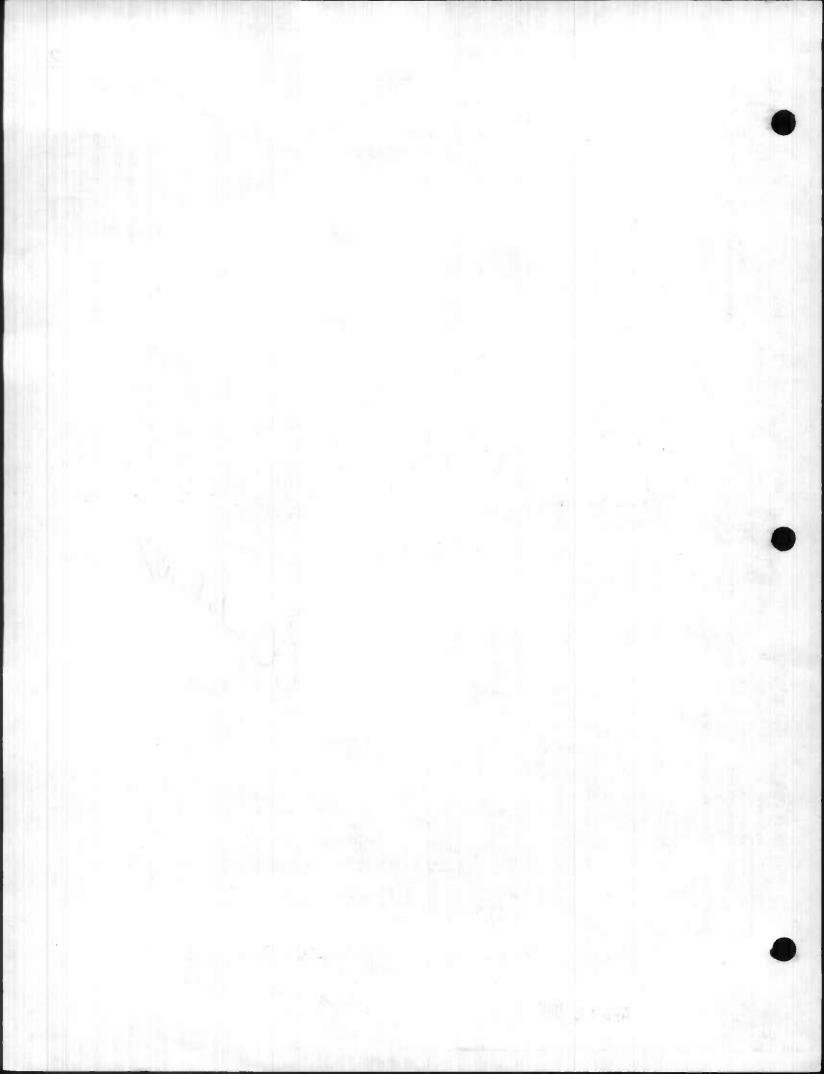


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	Certificate of Death	Be	eg. No.	
ician	1. Decedent'a Neme (First, Middle, Last)	2. Date of Deat Month	h Dey Yeer	3. Time of Deeth
	DELORES E. PARKS	April	1 200	A H A A A A A A
al er		n, or Location of Death	4c. County of Dea	ath
		TIMORE		
	214 22 5190   10 M 2 M F   71 Yrs.   1	Min. 8. Dete of Birth Month, Day, 6/1/28	Year) 9. Bi	hthplece (State or Foreign MD.
	Usual Residence of Decedent           10e, Stata         10b, County         10c, City, Town or Location			10d. Inside City Limits
Director	MD. BALTIMORE		1# Yes 2□ No	
	10e. Street and Number 10f. Zip Code 2441 DORTON CT. 21230	1	0g. Citizen of What C USA	Country?
by Funeral	11. Mentel Status  1 Nevar Married 2 Married  1 Nevar Married 2 Married  3 Widowed 4 Divorced  12. Was Dacedent Evar in U,S. Armed Forces?  1 Yes Floor 1 Yes, Sipce If Yes, specify Cuben, Maxican, If Yes, Sipce I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Bleck, Wh Specify: A	
ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work dona during most of		16b. Kind of Businas:	s/Industry
Completed	Elementery/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) HOMEMAKER	, voicing	НО.М	Œ
Be C	17. Fathar's Nema (First, Middla, Last) 18. Mother's	s Neme (First, Middle, I	Aaiden Surneme)	
To	ALBERT PARKER	HAZEL	BROWN	
	19a. Informent's Neme/Relationship (Type, Print)  19b. Meiling Address (Street and Number	or Rural Route Number	, City or Town, State,	, Zip Code)
	ALICE CRUMPLER 1918 N. PAYSON			
	20e. Method of Disposition  1  Suriel 2  Cremetion 3  Ramovel from State  4  Donation 5  Other (Specify)	1/7/2000	20c. Location - City o	
	21. Signature of Funaral Service Licensee  Level (4)  22. Name and Address of Fecility ESTEP BROTT  1300 EUTA			
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as ca shock, or haart failura. List only ona ceuse on aech line.	ordiec or respiretory error	est,	Approximate tnterval Between Onsat and Death
1	immediate Cause (Final disease or condition resulting in death)  e. Infected Retroperitoned h	umatom	a	17 days
iner	ESRD on Haumodialys,	S		12 years
i Examiner	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause, (Disease or injury c	'n·		2 years
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clar		1 22 200		
Physician/	Part II. Other eignificant conditions contributing to death but not resulting in the undarlying causa givan in Part I.  Type II Drabetes		PL BALTO. MD. 21217  ac or respiretory errest,  matoma  17 days  12 years	
leted by		24a. Wea e perion		evailable prior to completion of causa
Completed		1 🗆 Ye	es al No	1 Yes 2 No
Be	examiner?	of Deeth (Check only on	(8)	
To	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nurs	ing Home 5 Reside		pecify)
Certification:	27. Menner of Death  1 Neturel 5 Pending investigation  2 Accident   28a. Dete of Injury   28b. Time of Injury   28c. Injury et Work?  1 Accident   28c. Injury et Work?  1 Yes 2 Neture   28c. Injury et Work?	0	ow injury occurred	
Certific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Si City or Town	treet end Number or i n, Stete)	Rural Route Number,
edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth and menner stated.			
M	29b. Signature and titla of certifier Delhumana, MD AT 24389		9d. Data signed (Mo.	nth, Day, Year)
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  LOVEEN PUTHUMANA, DEPARTMENT OF MEDICIN		1 EMORIAL	HOSPITAL
tate	31. Date filed (Month, Day, Year)  32. Registrer's Signature	1		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #28b PER ME G782 4/12/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:53 AM 2000 /Medical 4a Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University 0+ mar Himore Baltimore Da If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 9, 9. Birthplaca (State or Foreig Country) Pennsylvania 5. Social Security Number Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 20 YES. 215-06-2817 Director Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Bel Air Harkord 238-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 2109 Windom Court 21015 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 21215-0020 b 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiens. Elamentary/Secondary (0-12) College (1-4or 5+) years Student College Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant! If tem 27 is marked off 8 Margaret Janetta Bollman Joseph Henry Popp 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 2109 Windom Court, Joseph H. Popp Bel Air. MD 21015 (Father) 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation Removal from State 1 □ Burial 2 □ Cremation 2 □ F 4 □ Denation 5 □ Other (Specify) Department of Important: If say Injury or Bel Air. Maruland Bel Air Memorial Gardens: 4/4/00 21. Signatule of Funeral Service 22. Name and Addrass of Facility Schimunek Funeral Home of Bel Air, MD 610 W. MacPhail Road, Bel Air, 21014 ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Dua to (or as a consequence of) Physician/Medicai Examiner APPROPRIEST BY MONTHS DEPARTMENT The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that initiated evants resulting in death) Last the buriel-tran Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): for use as 23b Old tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pall of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown eumonia Completed by Respiratory Distress Syndrome 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of cause of death? Failure Rena Ut 1 Yes 2 No 1 ☐ Yes 2 No Physician: 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) examiner? 1 Ves 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Mpnth, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Division or Attending 1 Natural 5 Pending investigation *ehici* March 25,2000 UNKNOWN 24 hours after deeth. 1 ☐ Yes 2 Z No 2 Accident the 28e. Placa of Injury - At home, farm, streat, factory, office Street building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Routa Number, City or Town, State) R+136 cc+ R+22 3 ☐ Sulcide in by 28f. 4 ☐ Homicide Churchville, 40 Hospitar 105-Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier completely (Check only one) within 2 ş 29d. Date signed (Month, Day, Year) 29b. Signature and Me of certified 29c. License number 10mo who completed cause of death (Item 23a) (Type, Print) (N.D 22 S. Greene Street, Baltimore, MD 21201 32. Redistrar's Signature 31. Data filed (Month, Day, Year)
APR 1 2 State Registrar



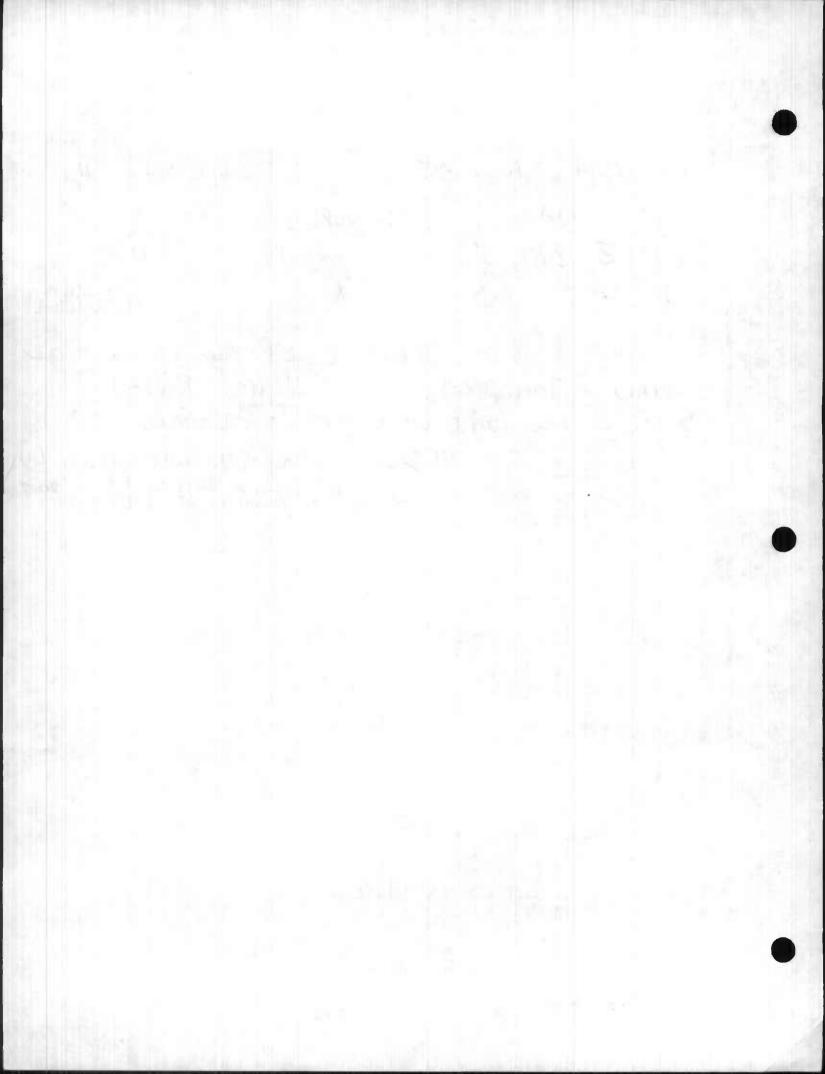


00-1931-033 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene PER MEO G782 4-15-00 WR.

1. 27, 28A-F Certificate of Death Reg. No. MICHELL LISA RIVERS AMEND ITEMS: #23 PART I, 27, 28A-F ent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** 18:08 PM APRIL 07, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGES 7. Age (In yrs, last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. July 13 5. Social Security Number 213-84-837 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 20 F Director Usual Residence of Decedent the Maryland State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 Yes 2 No Director MOK 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 V No If Yes, Give / Year or Dates: Harne Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race American Indian 11. Mentel Stetus Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1□ Yes 20 No Baltimore, Maryland 21215-0020 "natural", or Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) al Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be and Mental marked P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health and Important: If Itam 27 is m any injury or other traum pace. 0 Morce 20c. Location City or Town, State Place of Disposition (Name of Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximete Interval Between Onsel end Death 23a Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final NARCOTIC AND COCAINE INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examine attending physician and for use as the burial-transit be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings 24a. Was an eutopsy performed? Completed eveilable prior to completion of cause of death? certificate has page 2 Yes 2 No / Yes 2 No of Vital 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division To the Hospital or Attanding 5 Pending investigation 1 Natural 1 Yes 2 No UNKNOWN hours after death. 2 Accident UNKNOWN 4-7-00 I Diractor: 6 CCould not be determined 3 Suicide Location (Street and Number or Rural Route Number City or Town, State) 14615 PHILLIPS 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) CT 4 Homicide HOME LAUREL, MD within 24 hours edical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 20 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Sign ature and title of certifier 29c. License numbe 29d. Dete signed (Month, Dey, Year) OCME APRIL 08, 2000 Le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCKÉ M YARON Penn Street, Baltimore, Maryland 21201 R 12 2000 32. Registrar's Signature 31. Date filed (Mog State

Registrar **DHMH 16 Rev 6/95** 

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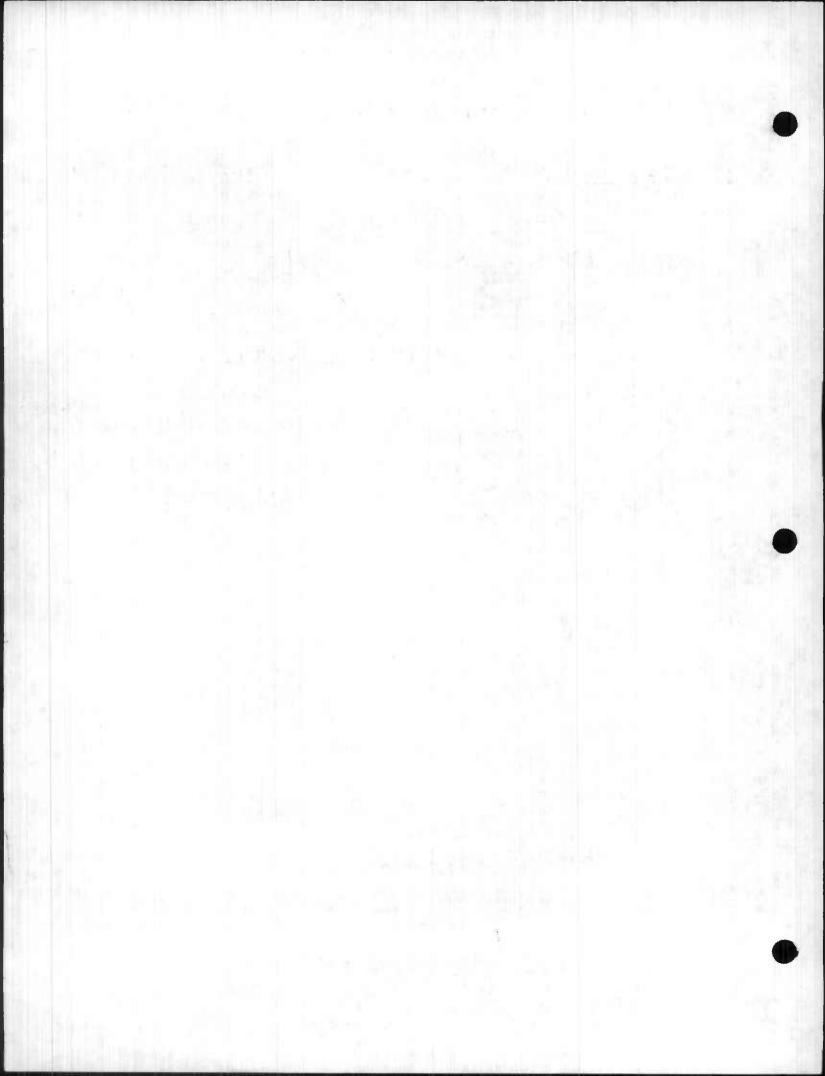
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Marvin Jeffrey Rice

State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	1. Decedent's Name (First, Middle, La	27, 28A-F PEF	, 0.	2.0	2. Data of Death Month	Day	Yaar	ime of Death				
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instrument by notified Funeral Director	10e. Street and Number	1 - 1	10f. Z	Tip Code	10	10g. Citizen of What Country?						
ms 23a	11. Marital Status	12. Was Decedent Ever in U	S. 13. Was Dec	edent of Hispanic Origin? (a ecify Cuban, Mexican, Pue	Specify Yes or No-		e - Amarican Ind	ian,				
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netu	15. Decedent's E (Specify only highest gri	ade complated)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of wa	orking	16b. Kind of Bu	usiness/Industry					
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treumatic To	19a. Informant's Name/Retationship	Fype, Print) Mother	19b. Mailing Addre	ss (Sigeet and Number or F	Jural Route Number,	City or Town,	State, Zip Code	21216				
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any injury	21. Signature Puneral Service Lice	V 364	22. Name	and Address of Facility	1 1 T W	mai Di	1	D, MU				
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y Physician/M			24e. Was a	24b. Were au available								
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 Day Year 4:00 Pm RAGINS APRIL JAMES 2000 4b. City, Town, or Location of Death RANDALLSTOWN 4a Facility Name (If not institution, give street and number) 4c. County of Death CENTER BALTIMORE. HOSPITAL NORTHWEST If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Months Hours 1XM 2□ F 577-26-4587 07 04 S.C. Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3217 Mayfair Road U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes X XNo Specify: 3€Vidowed 4 Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th grade Trackman Bethlehem Steel na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) James Ragins Ellen Weathers 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1702 East 31st Street, Baltimore Md Odessa Justis-Daughter 21218 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate XIXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Woodlawn Cemetery 4-14-00 Baltimore, Md 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part 1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final proinomon disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uas contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was cese referred to medicel exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) APRIL 09<sup>TH</sup> 8000 29b. Signeture and title of certifier

Examiner Box 68760. P.O. Division of Vital Records, Attending Physician: or Attending after death. Director: Aft

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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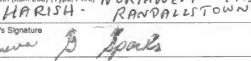
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AVYERAHALLI 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) NORTHWEST

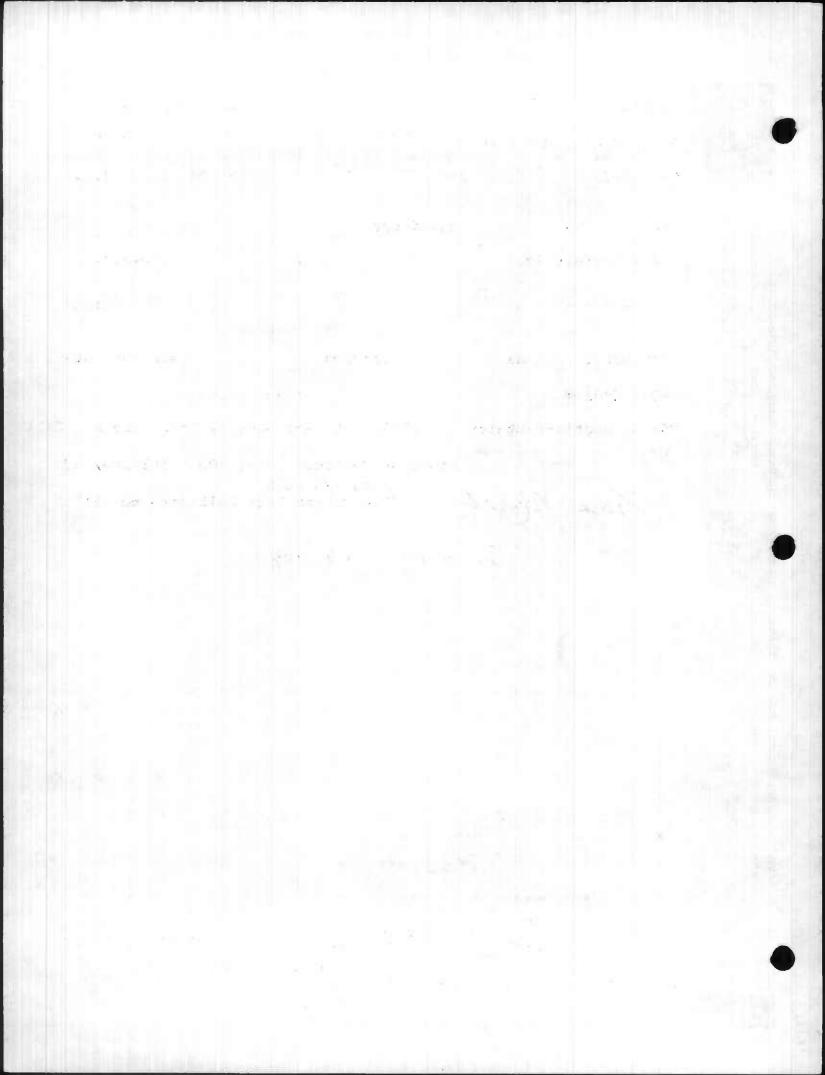
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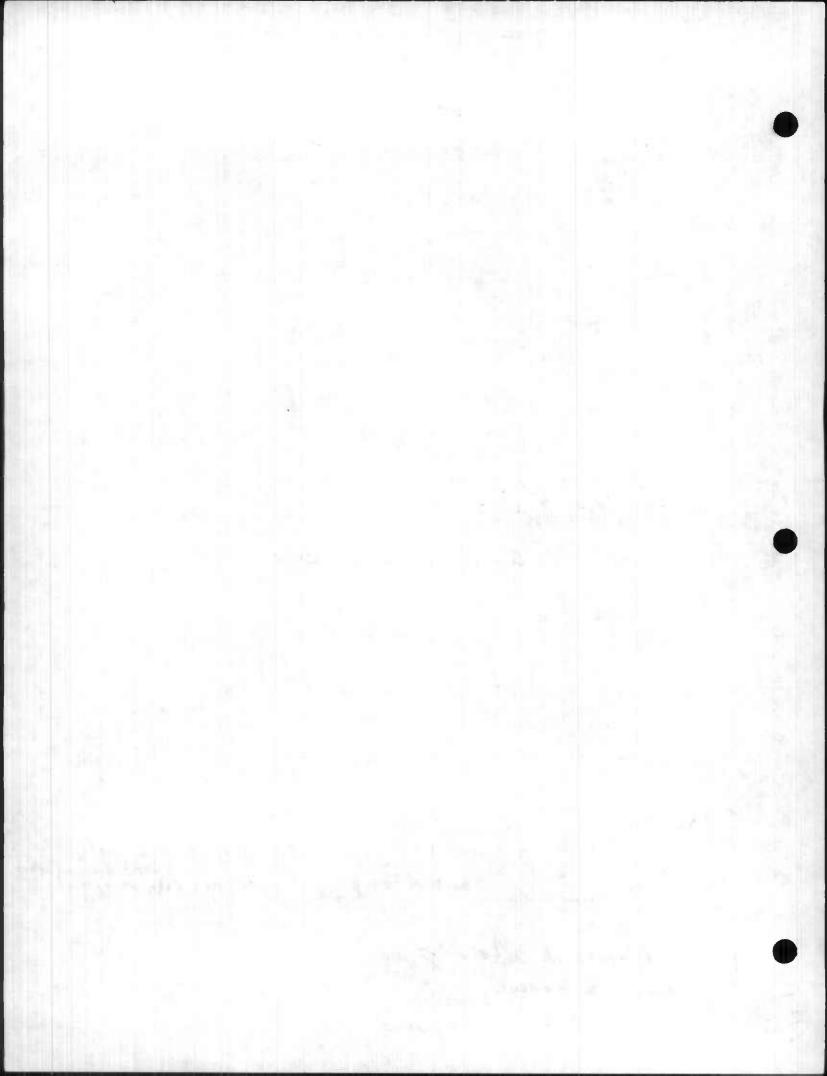
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State of Maryland / Department of Health and Mental Hygiene

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NSON	Certificate of Death Reg. No.																		
	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Decedent's Name (First, Middle, Last)											of Death							
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ctor	216-11-9812	1 1 1 1	Ø 2□F	2	25 Yrs.	IVIOINI	Doyo	110010		MAY 29			LAND						
-	Usual Residence of Decedent																		
	10a. State 10b. Count	y		10c. Cř	ty, Town or L	ocation						1	0d. Inside	City Limits					
6	5 CARVITAND N/A												1 € Ye	s 2 No					
5	MARYLAND N/A BALTIMORE CITY  10e. Street and Number  10f. Zip Code										son Citings o	4 What Cour	-t2						
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9	11. Marital Status		2. Was Dec	Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							ace - Americ								
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by	3 Widowed 4 Divorce		If Yes, Gi								Spec	city: BLA	ACK						
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ete	15. Decede (Specify only high	est grade	ation completed)	edent's Usua e kind of wor	k done	duning mos	t of worki	ing	16b. Kind of	Business/in	dustry								
Completed	Etementary/Secondary (0-12)		College (	1-4or 5+)	life.	(Give kind of work done during most of work life. DO NOT use retired)													
5	12th grade				PLUMBER/BELL TECH					COM		UNICAT	NOI						
0	17. Father's Name (First, Middle	, Last)			18. Mothe			er's Name	(First, Middle,	Meiden Sum	eme)								
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	19e. Informent's Name/Reletion	ship (Typ	e, Print)		19b. Mai	ling Address	(Street	and Numb	er or Rura	al Route Numbe	er, City or Tox	vn, State, Zip	Code)						
	Jeanette Robi	nson	/Mothe	er	918	N. WOO	DIN	GTON	ROAD	, BALTI	MORE,	MARYLA	AND 2	1217					
	20a. Method of Disposition			20b. I	Place of Disp	osition (Nam	e of	201		Date	20c. Locatio	n - City or Te	own, State						
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	21. Signature of Fundami Service	e Licanse	1/			22. Name and				MANATINIT MSZ	DIMED	AT HOM	ATT DA						
	WILLIAM C BROWN COMMUNITY FUNERAL HOME PA																		
1	Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line.  Approximate Interval Between											nate							
	shock, or heert failure. Lis	st only on	cause on	each line.	iii. Do iiot oi	itor the moo	o or ayıı	19, 35011 40	· oardiao (	or rought orony at	1001,	1	Interval 5	Between					
	Onsel and Death																		
	Immediate Cause (Final disease or condition Gunshot wound of Shest																		
	disease or condition resulting in death)	a.	_ Co U					Chie	31			1							
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Examiner		a b										i							
E	Sequentially list conditions,			Due to (	or as a conse	equence of):													
ĭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											1							
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0	1 Neturel 5 Pend			ith, Day Year)	Injury	AM	8c. Injut Wor		rate .										
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	Mysh	1	V	ner	4,1	1P													
	30. Name and eddress of perso	n who con	npleted cau	se of death (Ite	rf 23e) (Type	e, Print)													
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AKA: Robertson, William

**Physician** /Medical Examiner Box 68760

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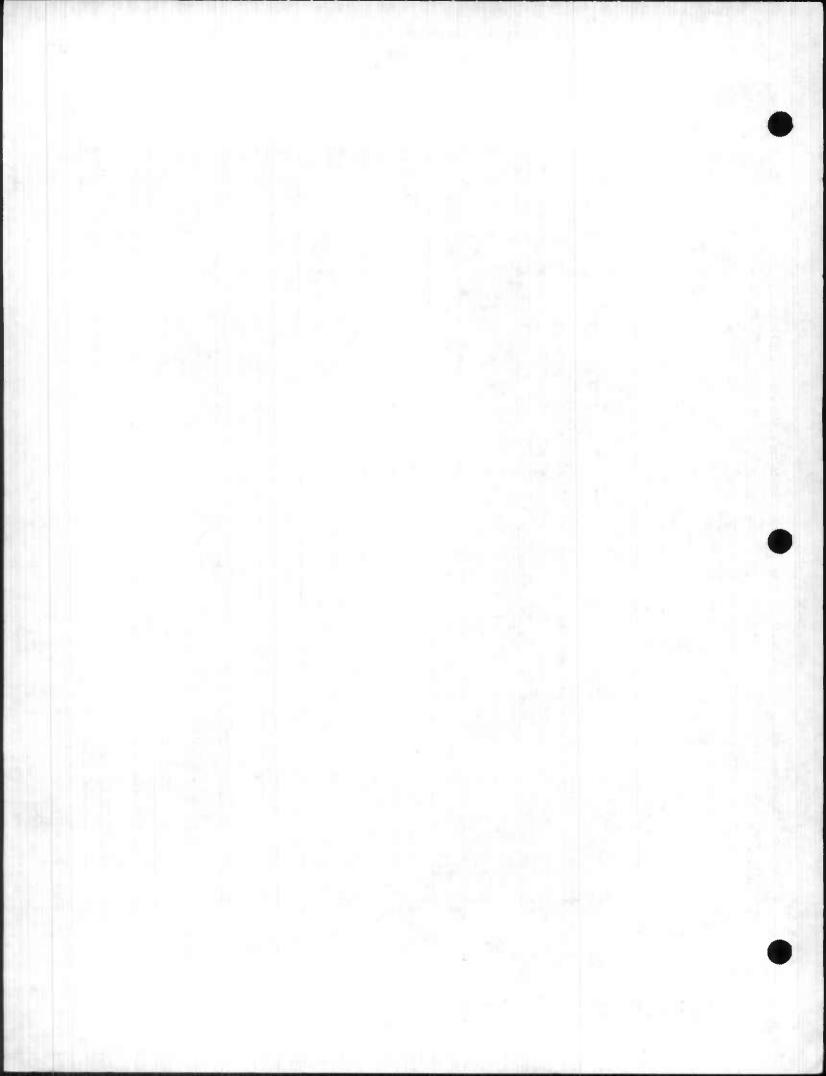
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Division of Vital Records,

3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 0525 am 2000 William H. Robertson April /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Fort Howard Baltimore VAMHCS Fort Howard Division If Under 24 Hrs. 8. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. 110 M 20 F 78 Yrs 226-28-5164 12-10-1921 Virginia Director Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at unknown unknown Md. 1 Yes 2 No Director 101. Zip Code unknown 10g. Citizen of What Country? 10e. Street and Number unknown USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 G Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify p Specify: Black 3 ☐ Widowed 4 ☐ Pivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry self-employed Elementery/Secondary (0-12) College (1-4or 5+) 7th Grade Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frazier Robertson Sissie Ann Jones 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sister Annie L. Weaver 7433 N. 21st Street Philadelphia, Pa. 19138 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philadelphia National Cem April 14 Philadelphia, Pa. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensee berber 2501 Gwynns Falls PKWY Baltimore, Md. 23e. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediata Cause (Final disease or condition resulting in death) 5 years Resected Carcinoma of Lung, Non Small Cell Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease p 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy Completed performed? 1 ☐ Yes 2 X No 1 Yes 30No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: \*\*Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Tyes 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred **N**O(Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a, Certifier XCCertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number Hashmi Sher A. Hashmi, MD April 9, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Sher A. Hashmi MD. 9600 North Point Road, Fort Howard Md 21052 32. Registrer's Signature Registrar oak

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 00 h April Asbury Cook Rideout, Jr. 07,2000 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St Agnes ltimore Health n/a 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 215-18-9069 1□M 2□F Months Days Hours 77 Yrs Sept. 14, 1922 Md Usual Residence of Decedent 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore 1□ Yes 2⊟No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Roberts Avenue 21228 USA 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX Year or Dates: 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry American Red Cross Elementary/Secondary (0-12) College (1-4or 5+) Supervisor/Blood Mobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumerne) Asbury C. Rideout, Sr. Ella Scott 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Viola E. Rideout wife 20 Roberts Avenue Catonsville, Md. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Md. National Memorial Park April 13 Laurel, Md. 22. Name end Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. derves nutter 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) leninpiti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Sic Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 robably 4 Unknown 1 TYee 2 No 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Wes case referred to medicat 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 EInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

/Medical Examiner Vitai o Division

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**Physician** 

/Medical

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**Funeral** 

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29c. License number P12595 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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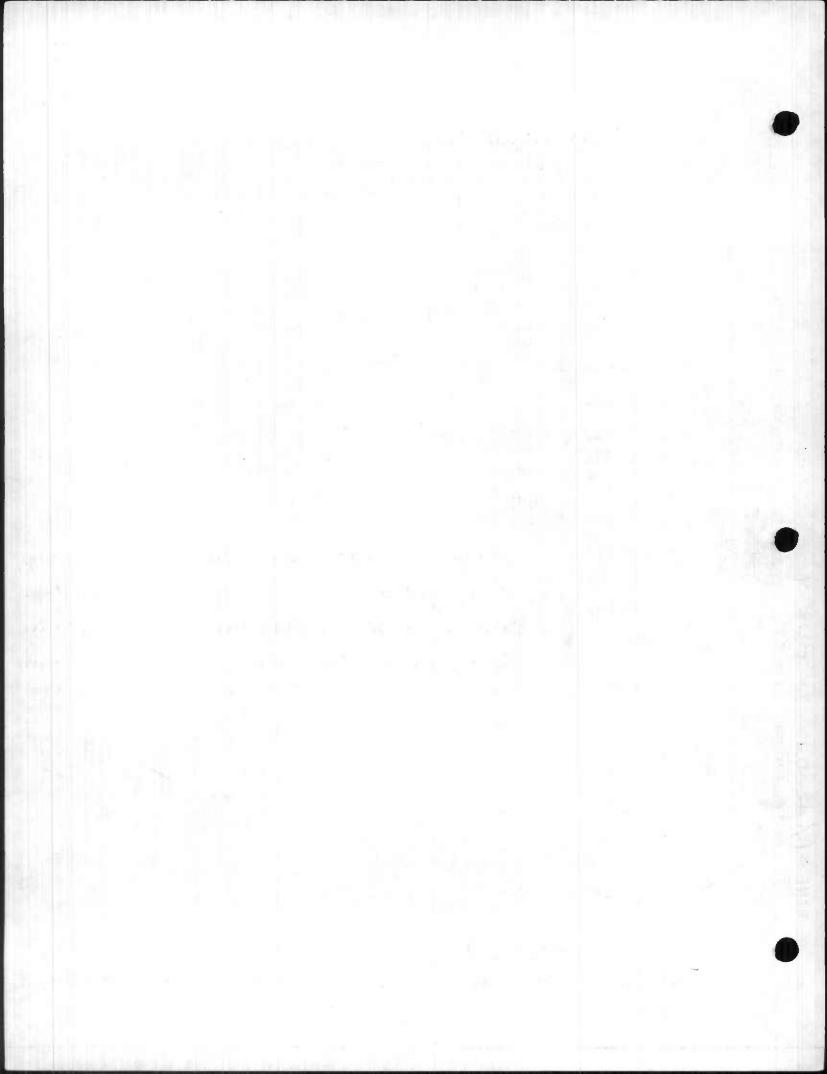
Avenue 900 Caton

31. Date filed (Month, Day, Year) APR 12 2000

29b. Signature and title of certifier

32. Registrar's Signature

Oak



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death March 28, Dey 2000 Year **Physician** Evelyn Rybarczyk 8:00 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore N/A If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Pay, Year) 4/19/1905 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☐ M 2 🖫 F 217-22-0223 94 Maryland Director Usual Residence of Decedent the Maryland 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or itema 23s or 28s-f show traumatic event, the Medical Examiner mast be notified at N/A MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2521 Hamilton Avenue 21214 U.S.A. Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: White 70 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Peges 1 and 2 should be filed within 'Department of Health and Mental Hygiena. Important: If item 27 Is marked other than 's any Injury or other traumatic event, are Mass and Dates. Elementery/Secondary (0-12) College (1-4or 5+) Assembly Line Bottling Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Lessner 2521 Hamilton Avenue Baltimore, Maryland 21214 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Oaklawn Cemetery 4/5/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licen 22. Name and Address of Fecility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner physician end s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of) that the deeth certificate be Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the the signed by t 3 Probably 4 WUnknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings evailable prior to completion of cause of death? should should 24a. Wes an eutopsy parlormed? Completed page 2 s 168 2 (1/No 1 ☐ Yes 2 No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Alinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 200No this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Injury Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide

Baltimore, Maryland 21215-0020

Box 68760 Division of Vital Records, P.O. Ne Hospital or Attanding Pin 24 hours after death. pletaly

> State Registrar

31. Dete filed (Month, Dey, Year) APR 1 2 2000

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29a. Certifier

(Check only one)

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29b. Signeture end title of certifie

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 Loch Raver, Balling , Ballimote,

Dalleler

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted.

29c. License number, D 30 66 1

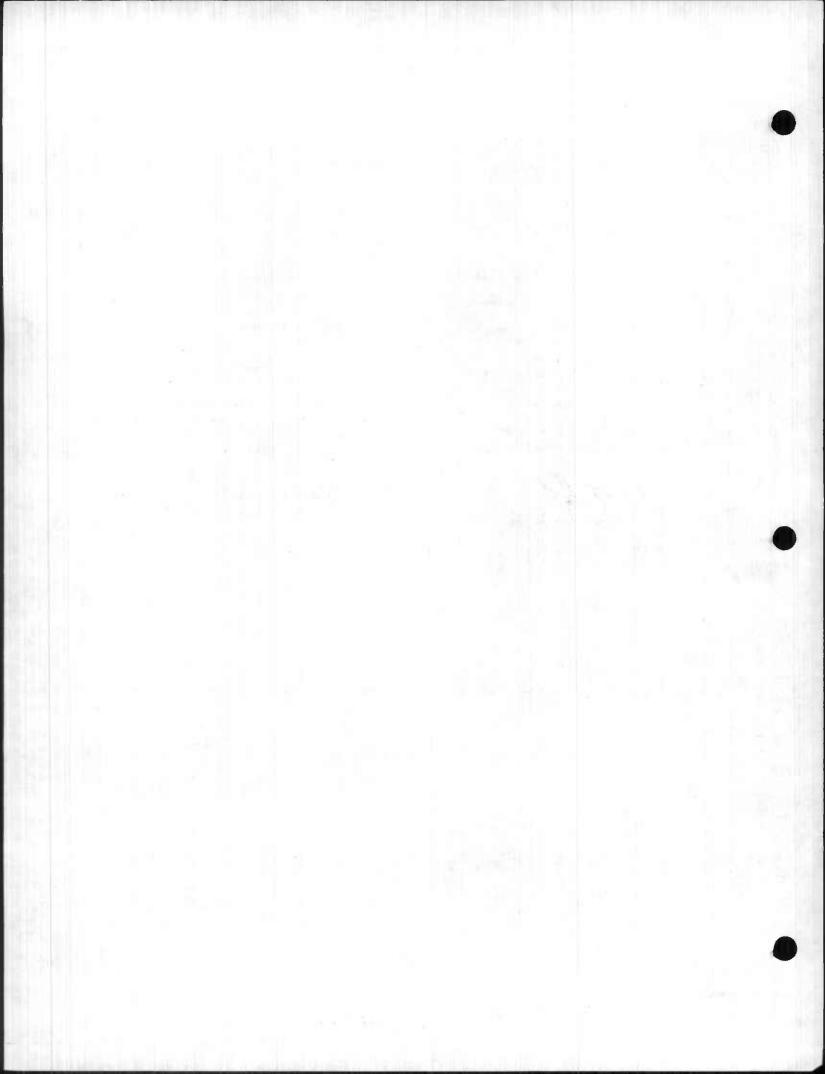
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Division of Vital Records, P.O. Box 68760, or Attending Physicien:

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State Registrar

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29b. Signature and little of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year) 11/00

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

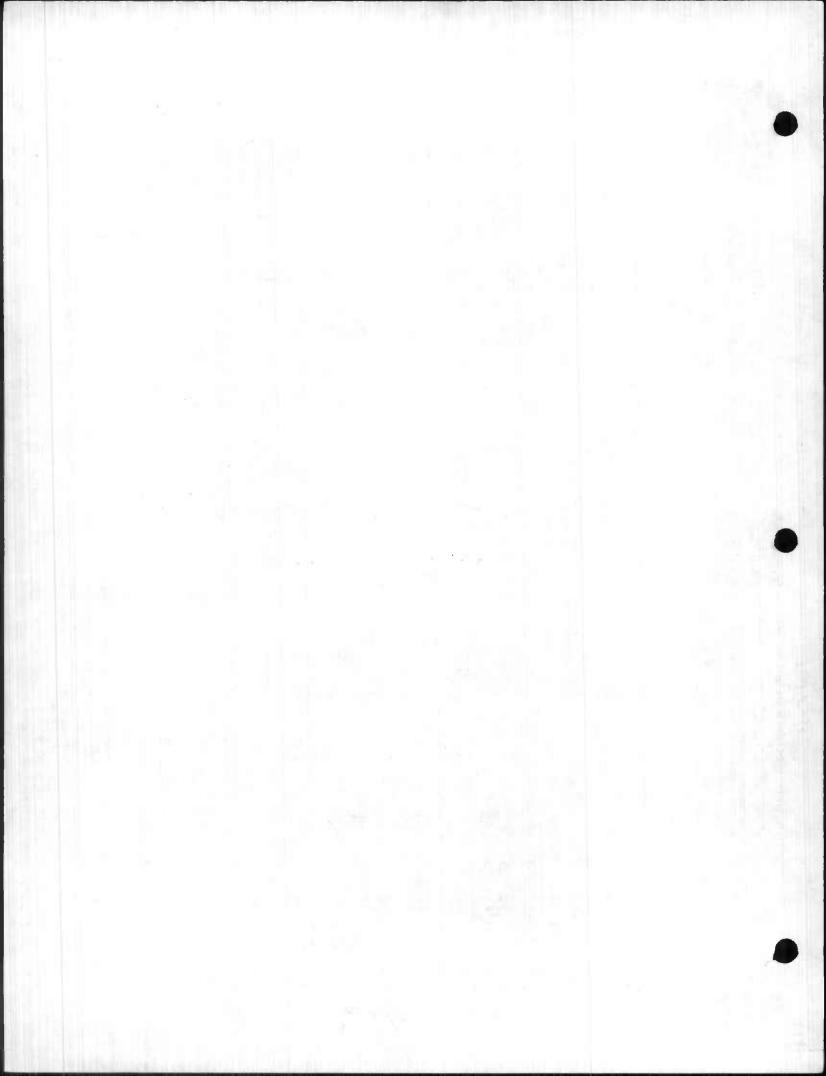
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD

31. Date filed (Month, Day, Year)

29a. Certifier

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32. Registrar's Signature



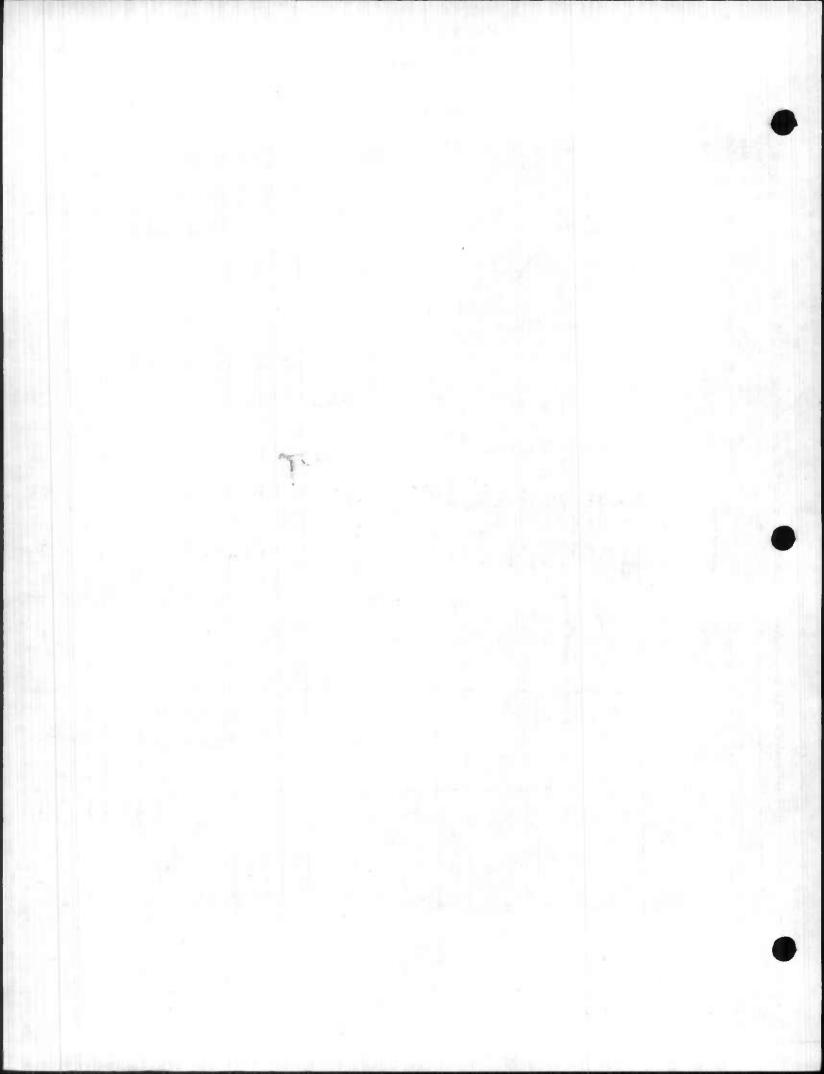
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** VICTORIA M. SARNECKI April 9,2000 11:30 am /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M XXF 59 Director 217-38-4856 5,1941 MARYLAND Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location show 10d. Inside City Limits ne 23a or 28a-f show 1 X Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 832 S. LUZERNE AVENUE 21224 U.S.A. Funerai Neme : 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced natural WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any Injury or other traumatic avant Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CASIMIR W. JABLECKI MARYANN KRUCZEWSKI 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL SARNECKI/HUSBAND 832 S. LUZERNE AVENUE, BALTIMORE, MARYLAND 21224 altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) STANISLAUS CEMETERY 4/13/00 BALTIMORE, MARYLAND 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest,

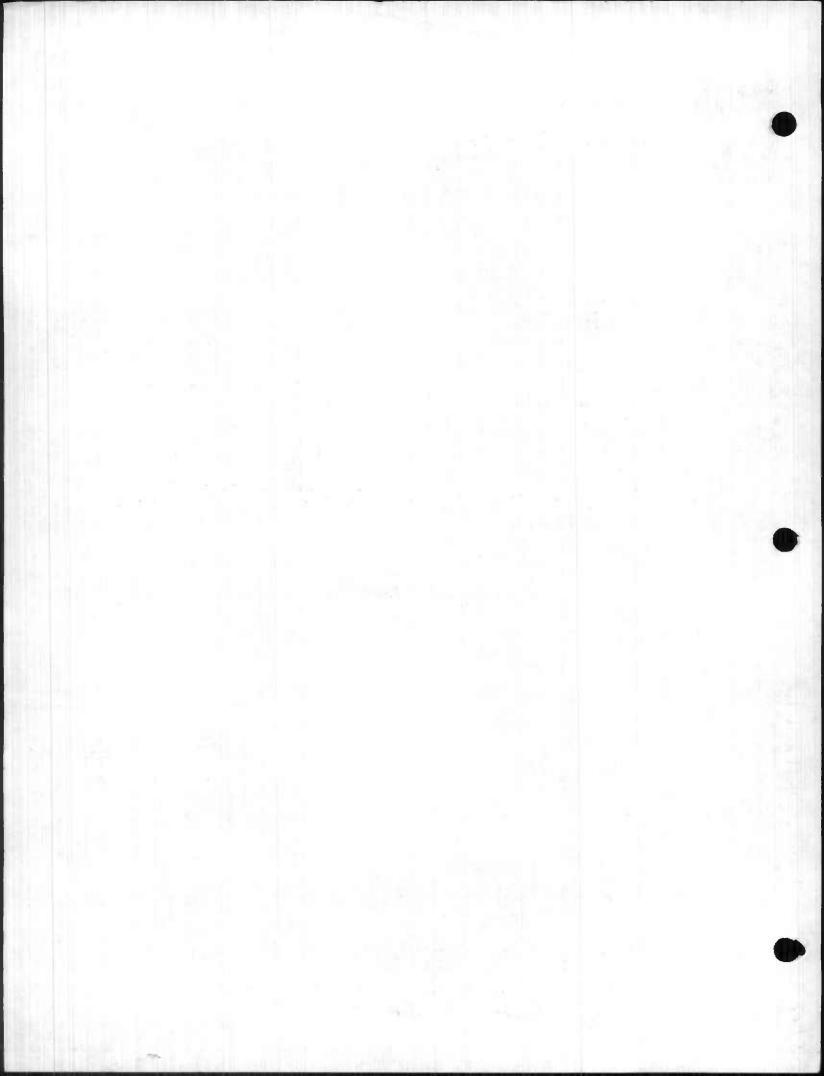
Approximate Approximete Intervel Between Onset and Deeth **Physician** of stomach months /Medical Immediete Cause (Finel AdenocArcinomA diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the cause of death? 3E Probably 4□ Unknown 1 ☐ Yes 2 ☐ No þ of Vital Records, 24a. Was an eutopsy performed? Completed 24b. Were autopsy tindings aveilable prior to completion of cause of death? has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Wes case reterred to medical exeminer? 8 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS Medical Certification: To this 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation Division 1 Neturel 2 Accident To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place and place and place. 29a. Certifier completely (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signeture and title of certifie uno 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) A. 6BMC 12 31. Dete filed (Month, Day, Year) 32. Registraris Signeture State APR12 2000 Registrar

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Please Type or Print in Biack Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Year **Physician** Oliver Nathaniel Smith 22:50 2000 DEL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SPITH Baltimore If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 10 M 2□ F 220-12-8024 75 Yrs. Director 24. 1924 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Howard Elkridge or 28a-1 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 5747 Race Road 21075 USA Funeral Herris 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Stetus hours after Yes 2 No 1 Nevar Married 2 Married 8 21215-0020 1 ☐ Yas 2 ♥ No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Prince George County Maintenance Engineer Schools altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Pages 1 and 2 should be sent of Health and Mental Oliver F. Smith Lillian Jackson 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6025 Bauman Drive, Elkridge, Md. Shirley Richardson - sister 21075 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 4/13/00 1 Burial 2 □ Cremetion 3 □ Removal from Steta Arbutus Memorial Park Arbutus, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funarel Sarvice Licenson 22. Nama end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. eles 7250 Washington Blvd., Elkridge, Md. 23a. Pen/. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete intervai Between Onset end Death Physician /Medical Immediete Cause (Final lamage diseese or condition rasulting in deeth) Examiner Due to (or as a consequence of): Examiner Metastatic Adenocarcinoma trostat the burial-transi Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Name: Smith, Oliver Physician/Medical Dua to (or as a consequance of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown g The law requires 24b. Were eutopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending Investigation 1 Yes 2 No death. e Hospital or Attendi 24 hours after death e Funeral Director: A 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) within 2 29d, Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number Ducke 1)000 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) calthare - 900 Caton Avenue - Baltimore MD Hicken Agnes William J. 32. Registrer's Signature 31. Date filed (Month, Day, Year) State Registrar

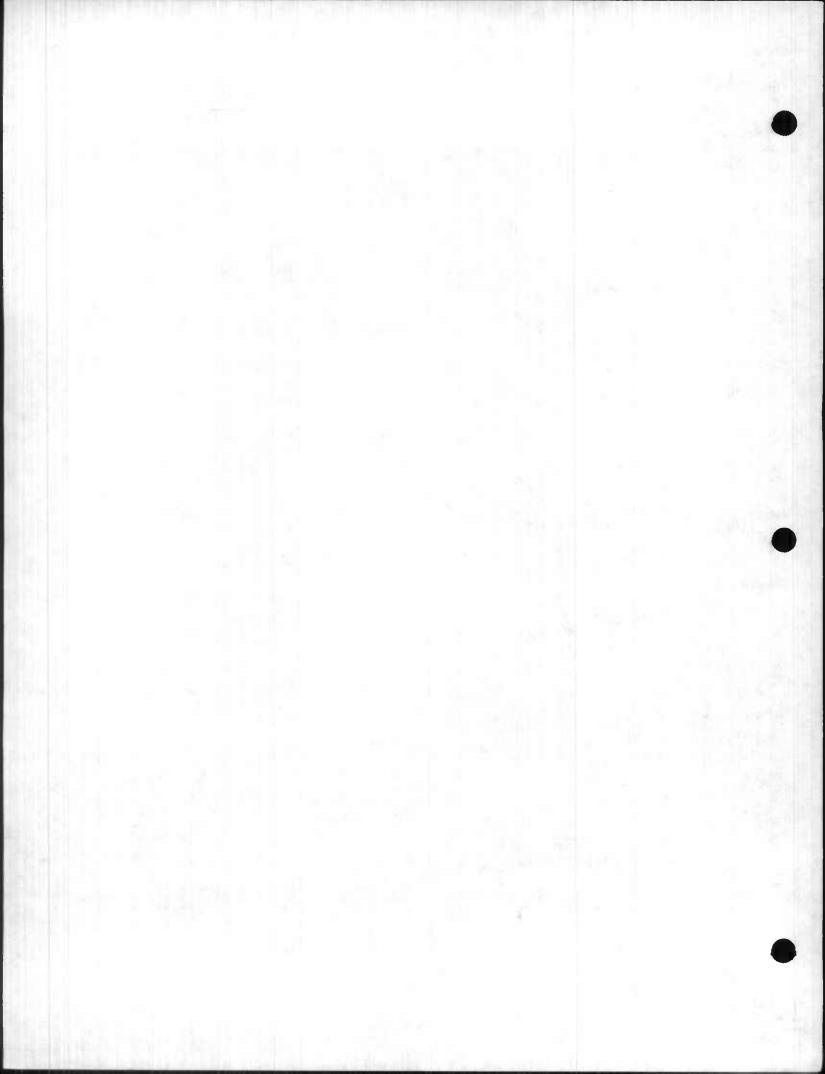


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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Angelo Andrew Torre Sr. April 2000 6:45 PM 6, 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3021 Brendan Avenue Baltimore N/A # Under 24 Hrs. 8. Data of Birth (Month, Day, Year) April 30, 1934 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Yrs. 215-30-8495 65 Maryland Usuei Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? 3021 Brendan Avenue 21213 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Iron Worker Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Santo Torre Maria Torre 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Angelo Torre (Son) 3502 Dunhaven Road, Baltimore, Maryland 21222 20b. Plece of Disposition (Nama of comatery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/10/00 Baltimore, Maryland Gardens of Faith 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Schimuner Funeral Home Inc. Mart 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart feilure. List only one cause on aech lina. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Disease UNKNOWN Due to (or as a consequence of) Sequentially tist conditions, if any, taading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Mitral Valve Replacement 1 Yes 2 No 3 Probably 4 Unknown Apric Valve Replacement 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No 1 ∏Yas 2 ∏ No 25. Wes case rafarred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home 28e. Date of Injury (Month, Day Year) Menner of Death 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Naturet 1 Yes 2 No

The law requires that the death certificate be executed physician as the burial Physician: Certification: To this After

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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filed within 72 hours after

Hygiene.

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/Medical

Examiner

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3 ☐ Suicide

29e. Certifier

4 Homicida

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29b. Signeture end title of certified

32. Registrar's Signature

Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number D0052420

Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, end dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year)

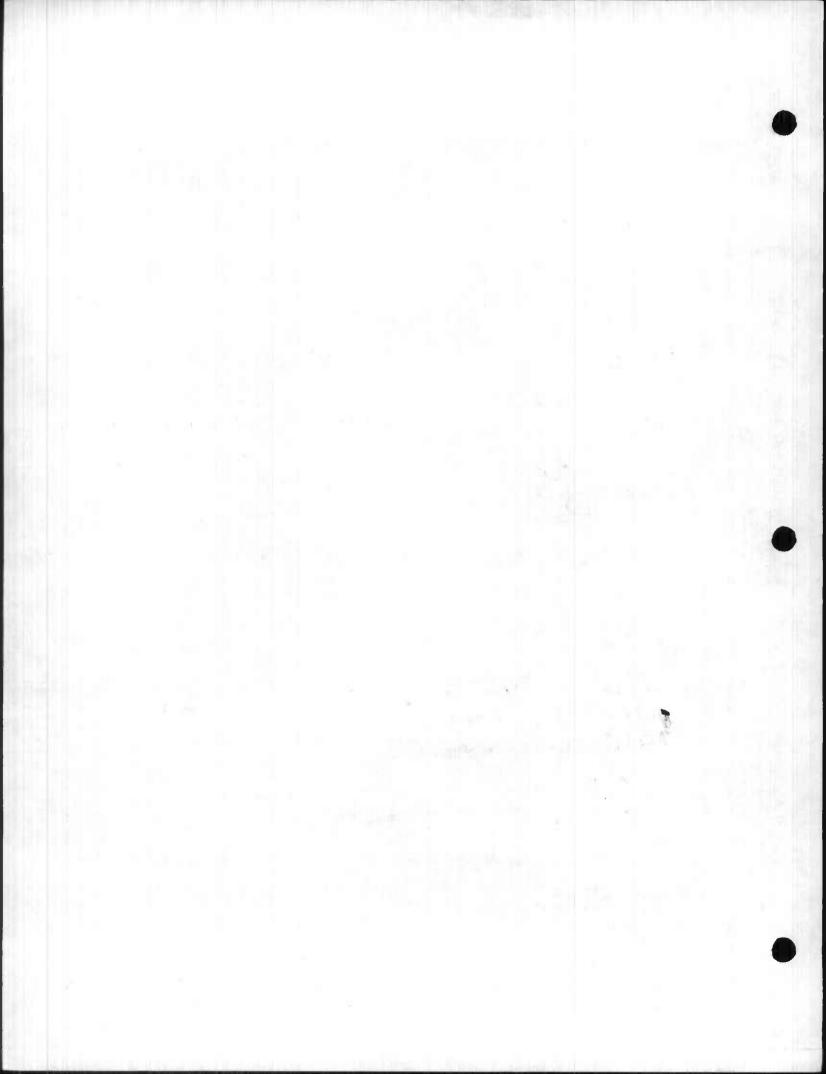
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** 4 ASUShi 9:55 AM TO6-0 00 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMON V nivers ity BALTIMORE MARYIMA Medical 0 H Under 24 Hrs. 8. Dete of Birth May 9, 1920 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days XX M 2□ F 213-42-8664 79 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2/X No Directo Maryland Baltimore Baltimore 258-7 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 13 Charlesbrooke Road 21212 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 200 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11 Merital Status filed within 72 hours after 1 Never Married 2 Married 8 1 ☐ Yes 2XXNo Specify: Oriental Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) 5+ Physician Hospital 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Masashi Fujita Haruko Togo 2 Pages 1 and 2 should Department of Health and M Important: If Nen 27 is man any injury or other traument 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kazuko Togo Wife 13 Charlesbrooke Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2/C Cremetion 3 ☐ Removel from State

Donetion 5 ☐ Other (Specify) 4/12/00 Baltimore, Maryland Greenmount Cemetery nature of Funeral Service Licens 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Pert1. Enter the diseer shock, or heert failure. for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, that only one pause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Aspiration **Examiner** Due to (or as a consequence of): Examiner GASTRO intestional The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bunial-trer metastastic Pancieatic Physician/Medical the Due to (or as a consequence of): USB 88 ŏ Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown director, page 2 should be detec 1 ☐ Yes 2 ☐ No λq 24b. Were autopsy tindings aveilable prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Beat 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel 1 Tes 2 No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) a

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

31. Dete filed (Month, Day, Year) APR 1 2 2000 State Registrar

30. Name and add

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M. LeMaile-Williams, MD 32. Registrer's Signeture

rson who completed cause of death (Item 23a) (Type, Print)

22 5 Greene St. Boltimore MD 200

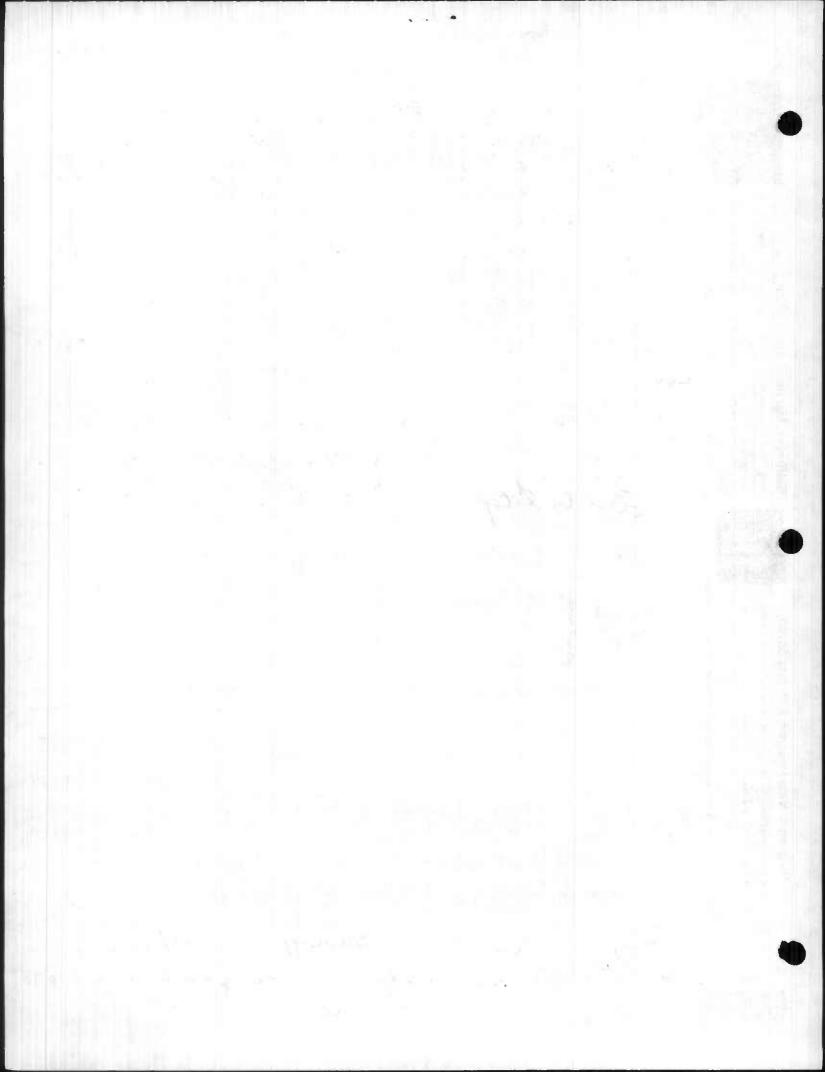
29c. License number

29d, Dete signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 00 11935

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To the Funeral Div	2	Syppe	complated cause of	death (Item 23a)	(Type, P	D40 Hamm	~491	Fern	r Ro	4/10 elin	1/00	m 210



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death APRIL STANLEY E. 7:15A TOLBERT 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE VA MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 11XM 20 F 213-20-9593 Yrs. Maryland Sept. 17, 1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ⊅ONo Edgemere Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 United States 7741 North Point Creek Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰¥es 2 □ No If Yes, Give Year or Dates: 1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 28 Married 1 ☐ Yes 2 Ho Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation

16a. Decedent's Usual Occupation

work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Manufacturing 12 Years 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father'a Name (First, Middle, Last) Lucy Bridges Emmett Tolbert 19a. Informent's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edgemere, MD 21219 Mrs. Virginia E. Tolbert 7741 North Point Creek Road 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 4/12/2000 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, list p by one cause on each line. Approximete Interval Between Onsel and Death 23a. Part1. Enter the distant Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA 1 WEEK Due to (or as a consequence of): YEAR COLON CANCER Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No

**Physician** /Medical Examiner Examiner

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examination must be notified at

2 should be filed within 72 hours efter ond Mentel Hygiene.
Is marked other than "naturel", or ite

permit. Pages 1 end 2 st Department of Health end Important: If item 27 is n eny injury or other traun

Saltimore, Maryland 21215-0020

the Meryland

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

PARKINSON'S DISEASE

25. Wes case referred to medical examiner? 1 Yes 2 No

> 1 Netural 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Corecadhay 29c. License number D32186 29d. Date signed (Month, Dey, Year) APRIL 8, 2000

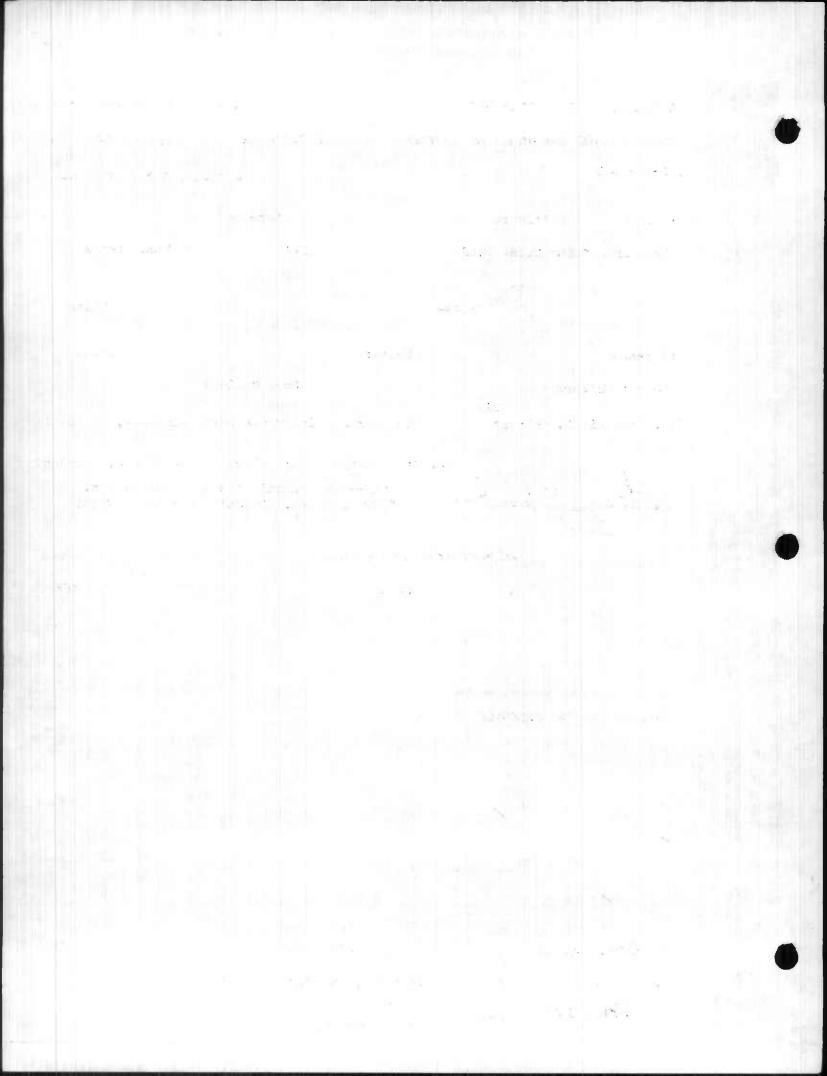
Registrar

CONRAD MAY 31. Date filed (Month, Dey, Year) APR 1 2 2000

32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

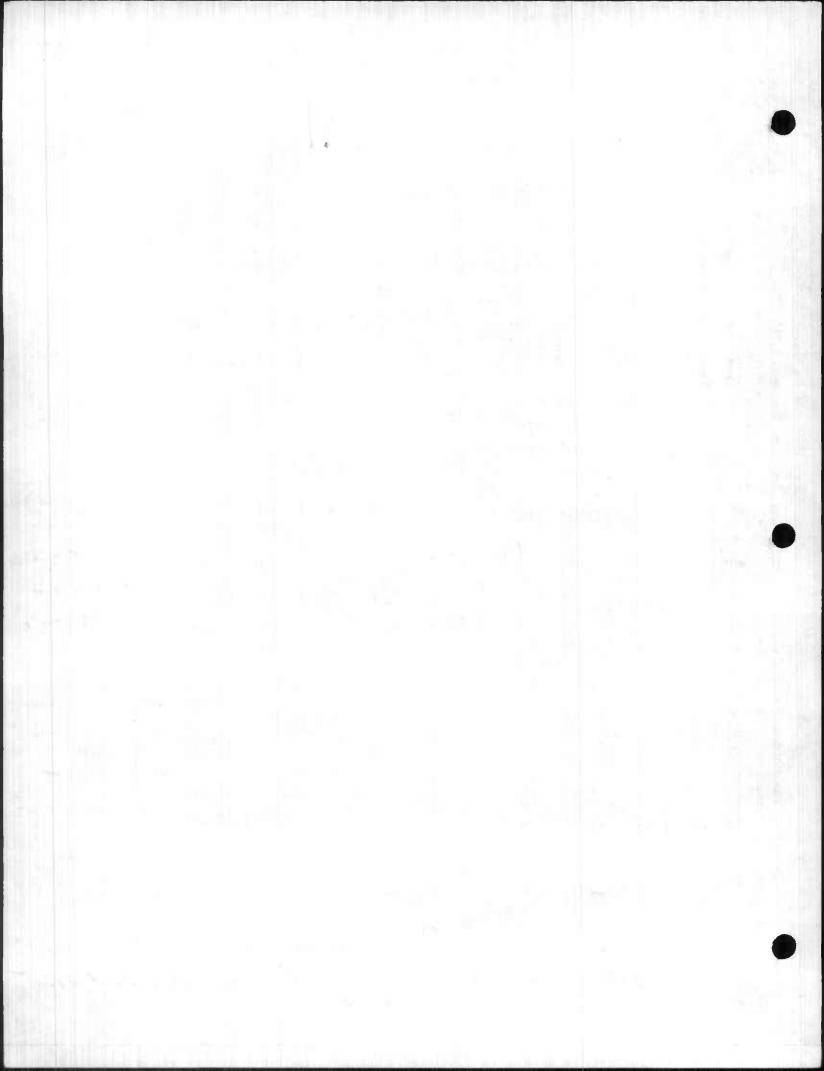
10 N. GREENE ST., BALTIMORE MD 21201 South



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Year 00 **Physician** SARANDA ANCES WASHINGTON 4b. City, Town, or Location of Death 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Baltimore of Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2 F 212-16-5432 Usual Residence of Decedent Yrs. 6 Director the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28s-f ahow Yes 2 No Director 3ALTIMOR MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Нетя 23в ARINTH YOAL USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 Nevar Married 2 Married "natural", or 1 Yes 2 No Specify: þ 3X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 ++ GRADE WORKER GLASS la marked other altimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be tension Pages 1 and 2 should be nent of Health and Mental CLARA OSHUA URNER ROBINSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRAND SHANTELL DOR DAN (DAUGHTEE) 36 / CLARINTH

20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If item 27 any injury or other tr RD. BALTIHORG, MD. 21215 Date 20c. Location - City or Town, Stata 20a. Method of Disposition permit. Pages Department of N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 04-14-00 OWINGS MILLS, MD 22. Name and Address of Facility 21. Signature of Furreral Service Licenses EPH H. BROWN CON. FULTON AVE JR. FUNERAL HOME 40 N Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. **Physician** Immediate Causa (Finel disease or condition resulting in death) /Medical hmig Examiner Due to (or as a consequence of): Examiner 00/4 myo Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760 tension Physician/Medical Dua to (or as a consequence of): the P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records. À 200 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 2 1 NO 1 ☐ Yes 1 Yes 2 No Division of Vital Physician: Be 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 25 ER/Outpatient 3□ DOA Medical Certification: To 1 Inpatient 27. Manner of Deeth Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Fig. 124 hours after death.
 Funeral Director: After 1 PNatural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

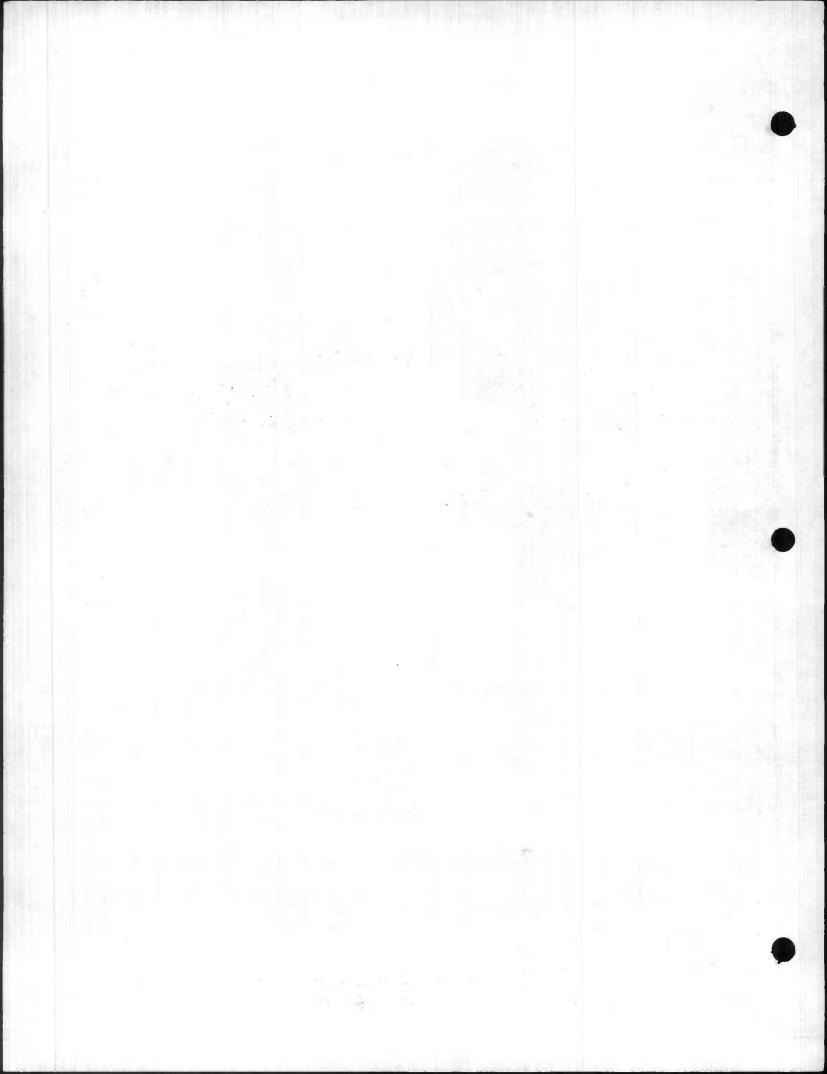
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of cardina 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 weller 6 31. Data filed (Month, Day. 32. Registrar's Signatur State Registrar DHMH 16 Rev 6/95



			Certifica	ate of Death	Reg. I	No.	11200
Dhualala	1. Decedent's Nama (First, Middla, I	1			2. Data of Death Month	Day Year	3. Tima of Death
Physician /Medical	Cecelia Co	THERING U	reidner		April 10		9:30 am
xaminer	4a Facility Nama (If not Institution,			4b. City, Town, or	Location of Death	4c. County of Dea	ath
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eral	5. Social Security Number 6	Sex 7. Aga (In yrs	s. last birthday) If Un Month	dar 1 Yaar   If Undar 24 Hr ns Days Hours Min		9. Bi	rthplaca (Stata or Foraign ountry)
tor	Usual Rasidence of Decedant		9 / Yrs.		Feb. 18 19	103 111	aryland
or notified at	10a. Stata 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
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luy	4 □ Donation 5 □ Othar (Spec		opeland N	Jem. Pack	2000 Pa	PRVILLE	Maryland
any injury or other traumatic avent, the Medical Earlings.  To Be Completed by	21. Signature of Funeral Service Liq	ensee 1 11	22, Nama	and Addrass of Facility	vars Fun	epal Cr	iapel
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be detached for u	Part II. Other significant conditions	contributing to death but not ra	sulting in the underlyin	g causa given in Part I.	23b. Did tobac		te to the cause of death?
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director, page 2	25. Was case refarred to medical axaminar?	Hoenitel:			eath (Check only ona)		
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Medical Certification:	(Check only 2 Medical Ex	hysician: To the best of my kn miner: On the basis of axamin	owledge, death occurre ation and/or invastigeti	ed at the time, date end plac on, in my opinion, deeth occ	e, end dua to the cause urred at tha tima, deta	a(s) and manner e and piace, and du	es stated. us to the cause(s)
completely filled in by the Medical Certifica	one) 29b. Signatura and titla of certifier	and mannar stated.		29c. License number		Data signed (Mor	
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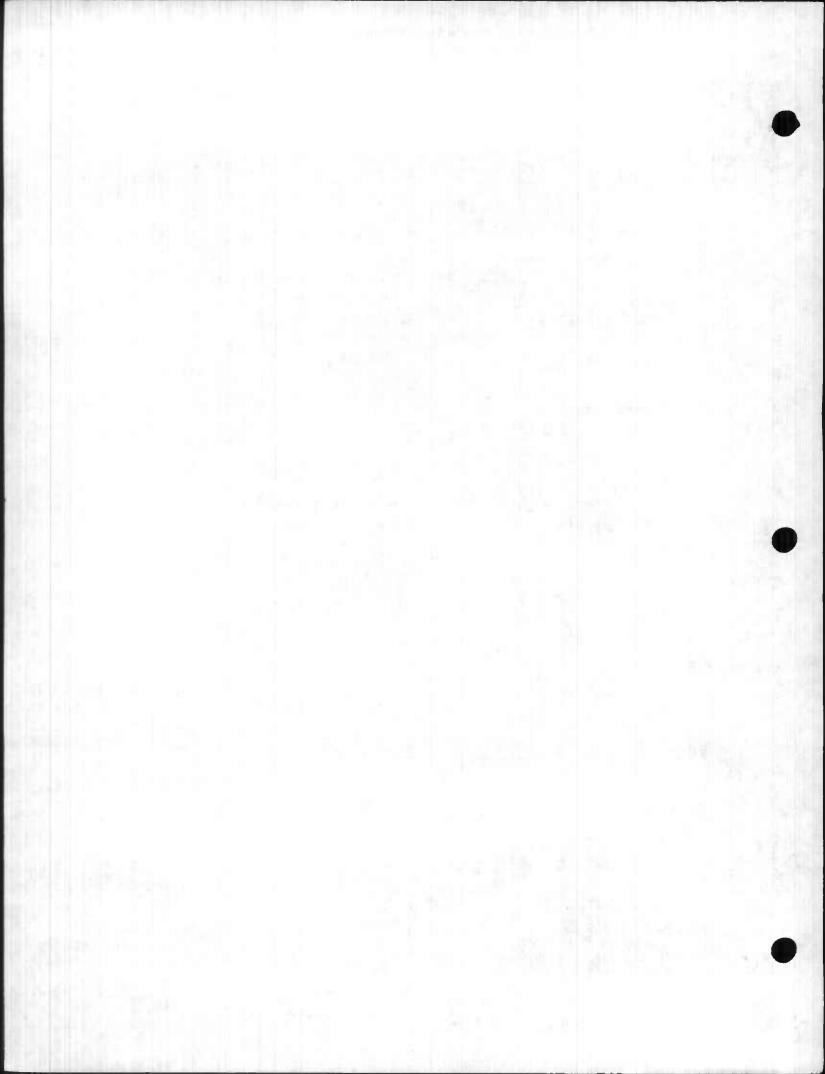
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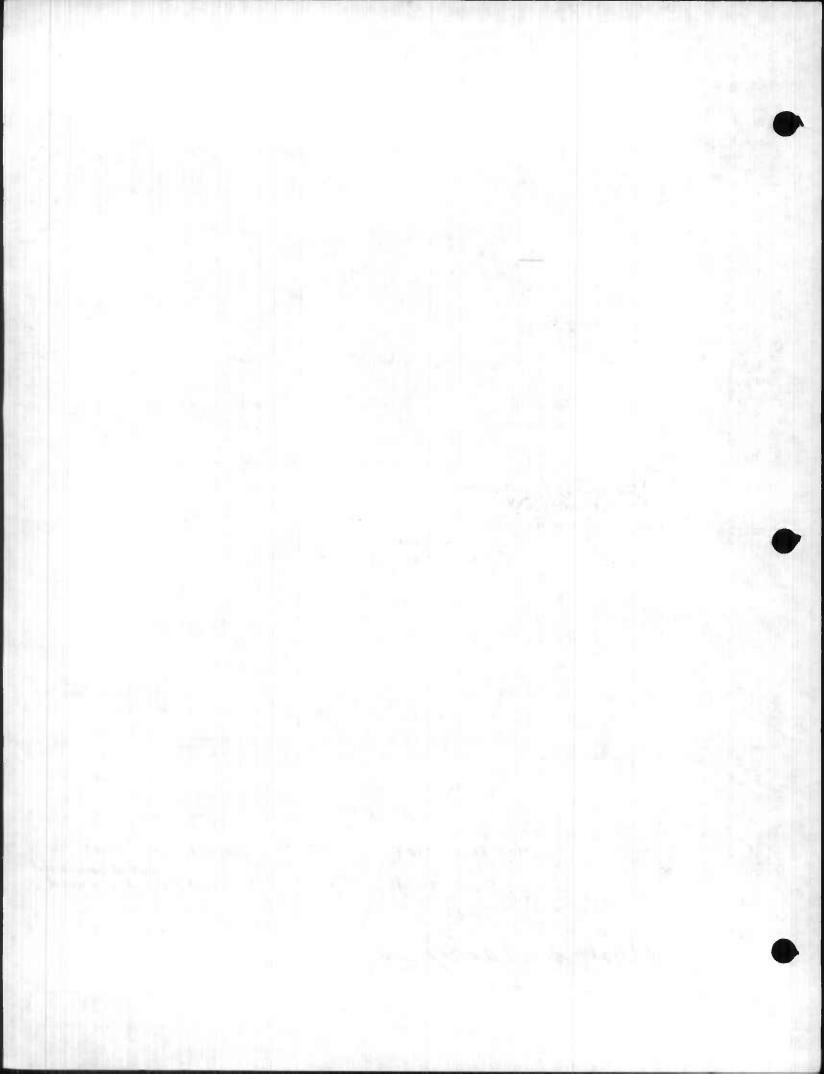
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152 Stonecroft  11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces?		If Yas, s	specify Cut	Hispanic Origin? (S ben, Mexican, Puer	rto Rican, etc.)	Blac	k, White, etc.	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva Year or Detes:		1 ☐ Ye	s 212 No	Specify:		Specify	Black	
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Elementary/Secondary (0-12)	College (1-4or 5	+)	Lab	orer			Frito	-Lay Comp	anv
17. Father's Name (First, Middle, Last,	)		2000			me (First, Middle,			
Jerome Walker					Bertin	a Pende	er		
19a. Informant's Neme/Relationship (	Type, Print)	198	. Mailing Add	ress (Stree	t and Number or R	lurel Route Numbe	er, City or Town,	Stete, Zip Code)	0.114
Tammie Walker-	Wife	1	52 St	onec	roft Ct	. Balt	imore	Md 21229	
20a. Method of Disposition		20b. Place o	f Disposition (	Name of	ace)	Date		City or Town, Stata	
XSurial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Stata		Memor			4-13-00	Randa	llstown,	Md
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	ysician: To the best o	my knowledge	e, deeth occur	red at the t	time, dete end place	e, and due to the	cause(s) and me	enner as stated.	
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(Check only XIX Medical Examone)  29b. Signature and title of certifier	Mac	Ag Page 1	MP (Type Print)						
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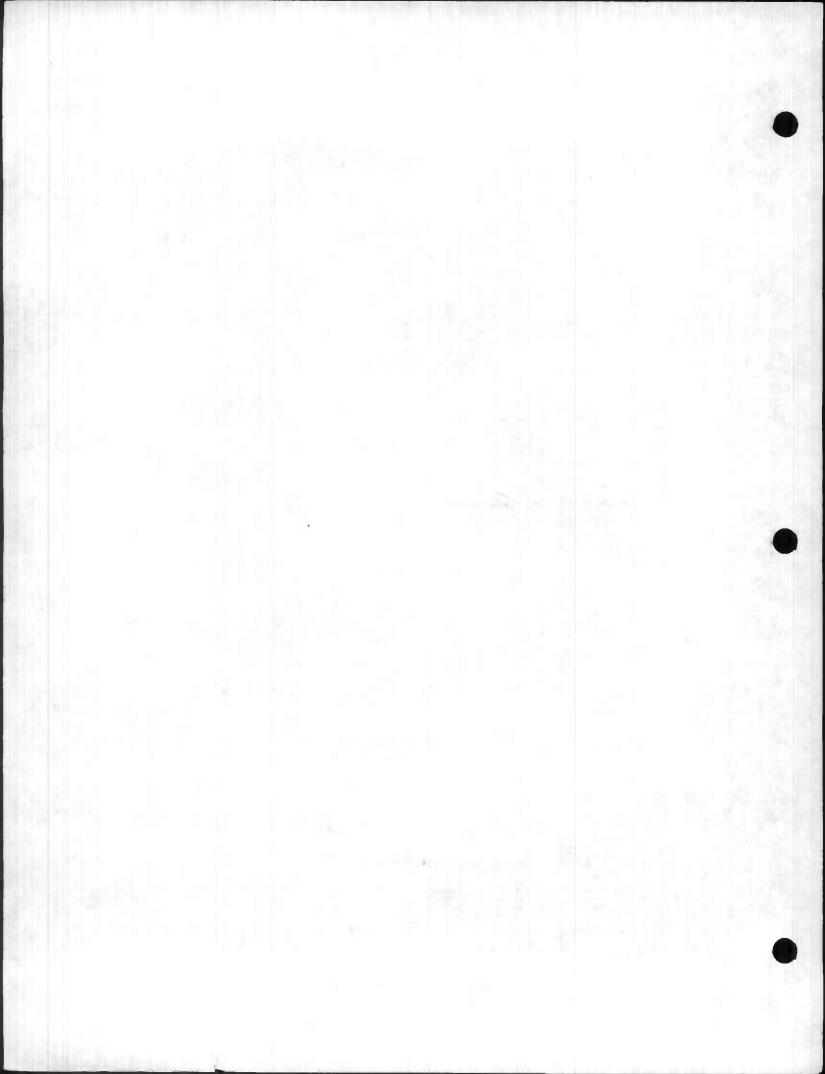
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State Registrar

31. Dete filed (Month, Day, Year)

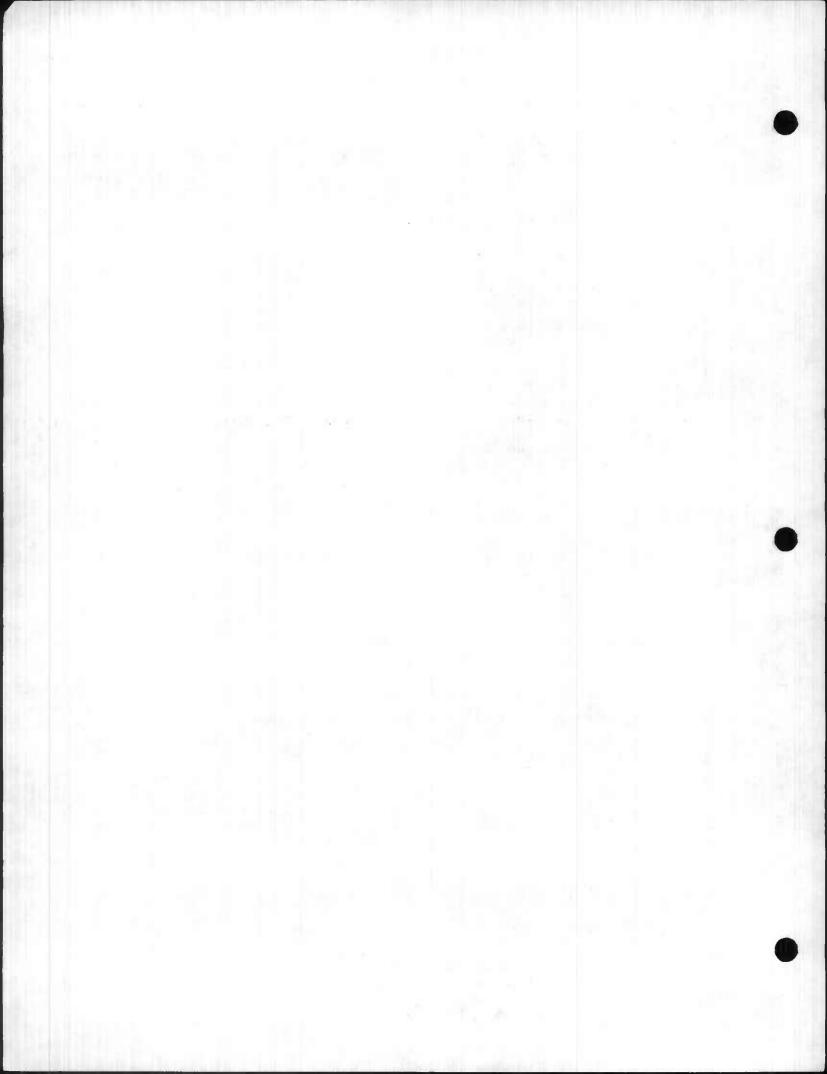
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32. Regetra's Signature



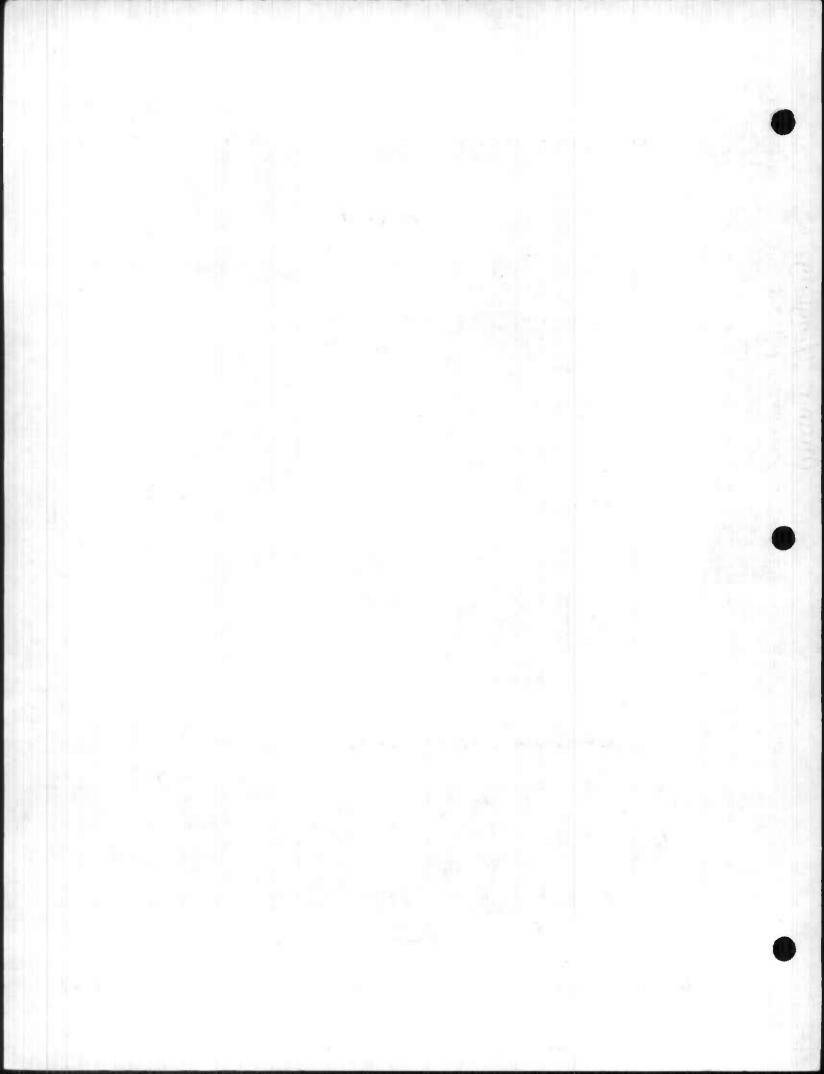
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Clifton Howes Wayson 9 2000 7:30 a.m. April /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1555 Governors Bridge Road Anne Arundel Davidsonville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10XM 20 F Yrs. 212-36-7439 74 Director Feb. 9,1926 Maryland Usual Residence of Decedent worle 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1555 Governors Bridge Road permit. Pages 1 and 2 should be filed within 72 hours after deeth v. Department of Heelth and Menial Hygiene. Important: if item 27 is marked other than "natural", or items 23a and injury or other treumatic event, the Medical Examiner mass 1806s. 21035 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽIŽNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar Preston Wayson, Sr. Grace Howes 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Mae Wayson (Wife) 1555 Governors Bridge Road, Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 04/12/ 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion U.M. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Lothian, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. ettla 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The lew requires that the deeth certificate be executed buriel-treneit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) physician s the buriel Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 980 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yaa 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed b Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Waa an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only gne) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Maturel 5 Pending investigation efter death. | Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in Hospital 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the F within 2 To the 29c. License number 29b. Signeture and title of continue 29d. Date signed (Month, Day, Year) DOO 22083 200 30. Name and address of person who completed cause probath (Item 23a) (Type, Print) George W. Uv. MID 116 Decense Au Defense they Suite 200 ann. m.D. 21401 George W. yu. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

	Certificate of D	Death	Reg. No.	+3
Dh	1. Decedent's Name (First, Middle, Last)	2. Date of D		e of Death
Physicia /Medica	MILIMITE DANGAMET TIMODING	Hor:	6,2000 11:10	2 A.M
Examine	er 4a Facility Name (If not institution, give street and number) 4b	b. City, Town, or Location of Dec	1	
	Franklin Square Hospital Center 1	Rosedale	Baltimore	
Funeral Director	214-26-5182 1 M 2 F 91 Yrs. Months Days	Hours Min. 8. Date of B		
Du .	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d foeids	e City Limits
short short				es 2 XNo
ith the Meryler or 28a-f show	MD. BALTIMORE OUF Phe 19.  10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?	A
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tems and	10 OVERLEA AVE.  11. Marital Status  12. Was Decedent Evar in U,S. Armed Forces?  1 Never Married 2 Married 1 D Yas 2 D No  1 Nover Married 2 Married 2 D Married	spanic Origin? (Specify Yes or h n, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, Whita, etc.	,
15-0020 Tyling of the 23a of the Earth of the 23a of th	1 Never Married 2 Married 1 Yas 2 No H Yes, Give X Yaar or Dates:	Specify:	Specify: WHITE	
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Maryland 212.  d 2 should be filed within the end Mental Hyglena. 7 is marked other than traumetic event, the traumetic event event, the traumetic event	17. Father's Name (First, Middle, Last)  LEVI RODGERS	18. Mother's Name (First, Middle IDA SCHUL	e, Maideri Sumame)	
Mary Mary and 2 sho asaith end A na7 is me or traume	19a. tnforment's Name/Relationship (Type, Print) 19b. Meiling Address (Street er	nd Number or Rural Route Num TREET, BALTI	ber, City or Town, State, Zip Code) MORE, MD. 21224	4
Baltimore, Maryland bemit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event,	20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 □ Ramoval from Stata  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place, HOLLY HILL CEMI	Date ETERY 4/8/00	20c. Location - City or Town, State BALTIMORE, MD.	
Baltil Benti. P Departm. Importer	21. Signature of Funaral Sarvice Licensee 22. Name and Address			
Physician /Medical Examiner	Immediate Cause (Final disease or complications that caused the death. Do not enter the mode of dying, shock, or paint failure. List only one ceuse on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or es e consequence of):	/	arrest, Approxim	21224 mate Between nd Death
6876( rifficate be ng physicia	Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. — Due to (or as a consequence of):  c. — Due to (or as a consequence of):			
O. E s deal	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I. 23b. DI	d tobacco use contribute to the caus	se of death?
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Division of Vital Records, P.O. or Attending Physician: The lew requires that the diafter death.  Director: After this certificate has been signed by the sin by the funeral director, page 2 should be deteched	CONFUSIONAL STATE / Chron	24a. We per	os en eutopsy formed? 24b. Were autops available pric completion c of death?	ior to
Re lew ha lew e has age 2	E C		Yes 2 No 1 Yes 2	2□ No
Vital I	25. Was case reterred to medical	26. Place of Deeth (Check only	•	
of Vital Re	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other		sidence 6 ☐Other (Specify)	
On Of sing Phys h. After this funaral di		at 28d. Describ-	e how injury occurred	
ondin oath.	2 Accident Investigation M 1 7	res 2□No		
or Atte	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Resembled 4 Resembled 2 Res		(Street and Number or Rural Route N own, State)	lumber,
3030	29a. Certifier (Check only one)  1 Certifying Physician: To the part of my knowledge, death occurred at the time of examination and/or investigation, in my opin and manner stated.	e, date and placa, end due to th inion, deeth occurred at the time	e cause(s) and manner as stated. e, date and placa, and due to the caus	se(s)
o the rithin o the omple	29b. Signature and title of certifier 29c. License	number	29d. Date signed (Month, Day, Year	r)
F3F0	· yannon	> 18326	4/6/00	)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	9	,	
	O. Nacom Gayhar 9000 Franklin Square Dr	ve Baltimo	re, MD. 2123	7
State Registra	31. Date filed (Month, Day, Year)  32. Registrar's Signature			



3. Time of Death

Physician /Medical Examiner	Į
Funeral Director	

'natural', or items 23s or 28s-f show

Baltimore, Maryland 21215-0020 PHYSICIAN: BARKER Pages 1 and 2 should be Health and Mental KNOWN TO P AMES K

**Physician** /Medical Examiner W

The law requires that the death certificate be executed P.O. Box 68760, the be del Records, page 2 should certificate Vital Hospital or Attending Physician: director, Division of this After death. within 24 hours after death To the Funeral Director: completely filled in by the

To the 5

James Franklin Barker APRIL 3, 2000 11:10 AM 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Y POINT CECIL VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months ountry) Virginia XXM 20 F 223-20-0567 77 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Ceci1 1 Yes 2000 Maryland Director Conowingo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 168 Conowingo Road 21918 U.S.A. Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: 1943-46 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry V.A. Medical Center Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Perry Point, Maryland Nurses Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clyde H. Barker Bertha Godsev 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Betty C. Barker (wife) 168 Conowingo Road, Conowingo, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Removal from State Harford Memorial Gardens 4/8/00 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. TOUTETLAN Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Causa (Finat CANCER OF THE PROSTATE WITH METASTASIS 4 YEARS disease or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 □ Yes 2 N No 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier

KAM KEN LEUNG, M.D., 31. Date filed /Month State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

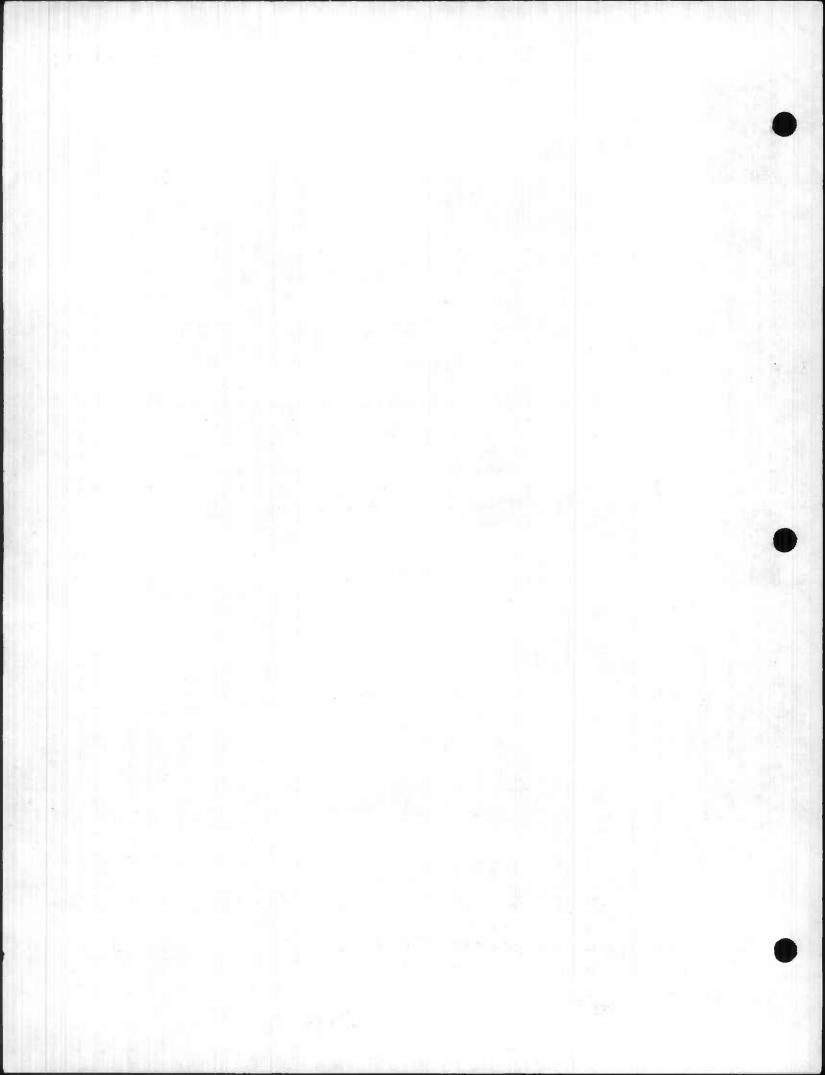
VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD

29c. License number

D16608

29d. Date signed (Month, Dav. Year)

APRIL 3, 2000



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\text{OP} Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year Physician BAR A-2000 8:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANCASTE POLIS nna H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 2I, 1943 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys Months 1□ M 20 F 415 680666 Yrs. Director Maryland Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other then "netural", or heme 23a or 110 Lancaster Court 21401 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. filled within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à Specify 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Demit. Pages 1 and 2 should be filled will Department of Health and Mental Hyglen Important: if Item 27 is marked other the any injury or other traumatic event, the page. Professor College 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Delura Shauf William Miller 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lois A. Pflugh / Friend 110 Lancaster Ct. Annapolis, MD 21401 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. Margaret's Cemetery 14-2-00 Annapolis, MD. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximata Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final Varian years disease or condition resulting in death) Examiner Examiner oreasi physician and a the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or es a consequence of) Box 68760, Physician/Medical that initiated events resulting in death) Last Dua to (or es a consequenca of): 200 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ Records, should l 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was an eutopsy performed? 2 0 No cartificata 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 8 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 中 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 2 Accident investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

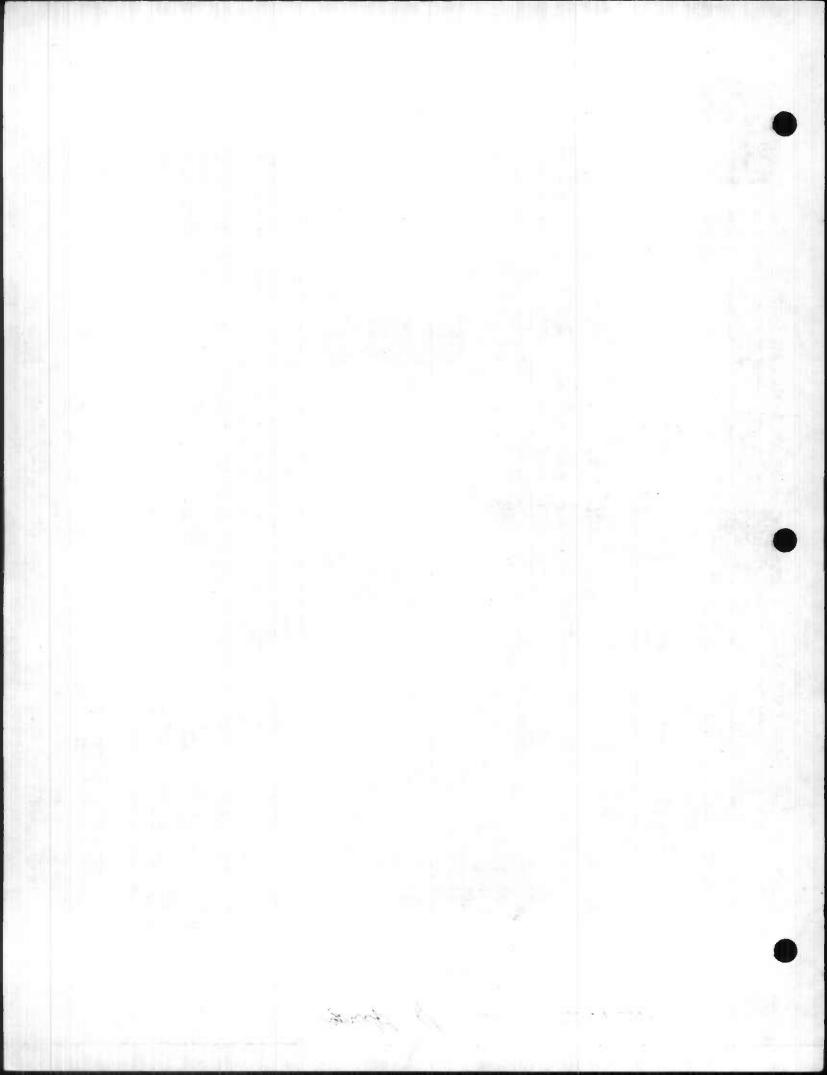
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier D52830 unne werey MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Werner eanine

State Registrar

31. Date filed (Month, Day, Year)

APR 03 2000

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** George Frederick Brauer March 5:00 AM /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 244 W. Joyce Lane Arnold Anne Arundel 5. Social Sacurity Number 6. Sex If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) March 30, 1933 7. Age (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 17 M 2□ F 214-30-4041 Director 66 Maryland Usual Residence of Decedent x 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Items 23a 244 W. Joyce Lane 21012 United States Funeral Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status 72 hours efter 1 Never Married 2√ Married 1 Yes 2 No If Yes, Giva A Yaar or Datas: altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "eny in|ury or other traumatic event, in the Elementary/Secondary (0-12) College (1-4or 5+) Interior Design 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Robert Brauer 2 Rose (Unknown) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catharina M. Brauer / Wife 244 W. Joyce Lane Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cramation 3 Removal from State
4 Donation 5 Other (Specify) Ft. Lincoln Crematory 03-29-00 Brentwood, Maryland Te Licensee 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical cardial infarction Examiner Vascular disease Physician/Medical Examiner atherosclerotic Sequentially list conditions, if any, leading to Immadiate ceuse. Enter Undarlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? coronary antery bypass ~1972 Yes 2 No 3 Probably 4 Unknown Records, Medical Certification: To Be Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy carotid endartere ctore completion of ceuse of death? hyperlipidemia 1 Yas 2 No Division of Vital 25. Was cese referred to medice! axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? After 1 Natural 2 Accident or Attending 5 Pending investigation a Funeral Director: Aft detaily filled in by the fur 1 Yes 2 No 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier completaly (Check only one) To the To the To the F 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier

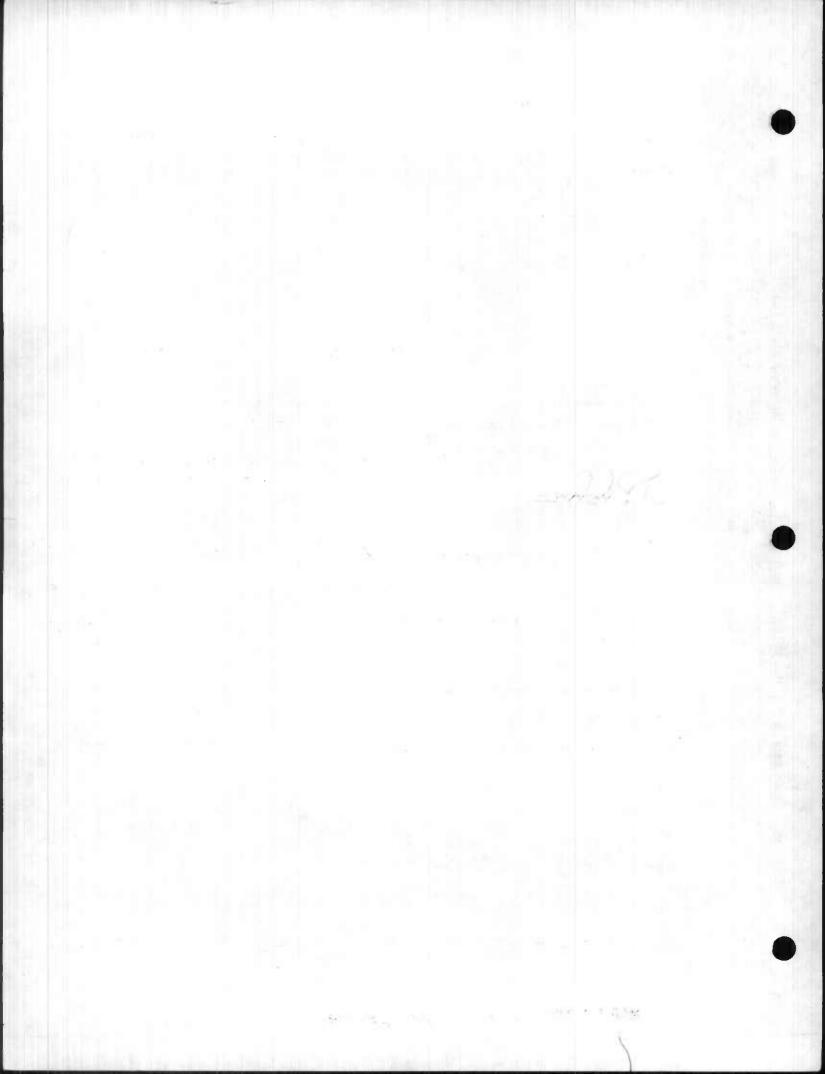
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30. Name and address of person who completed ceuse of death (Item 23a) (Typa, Print)

32, Registrar's Signature

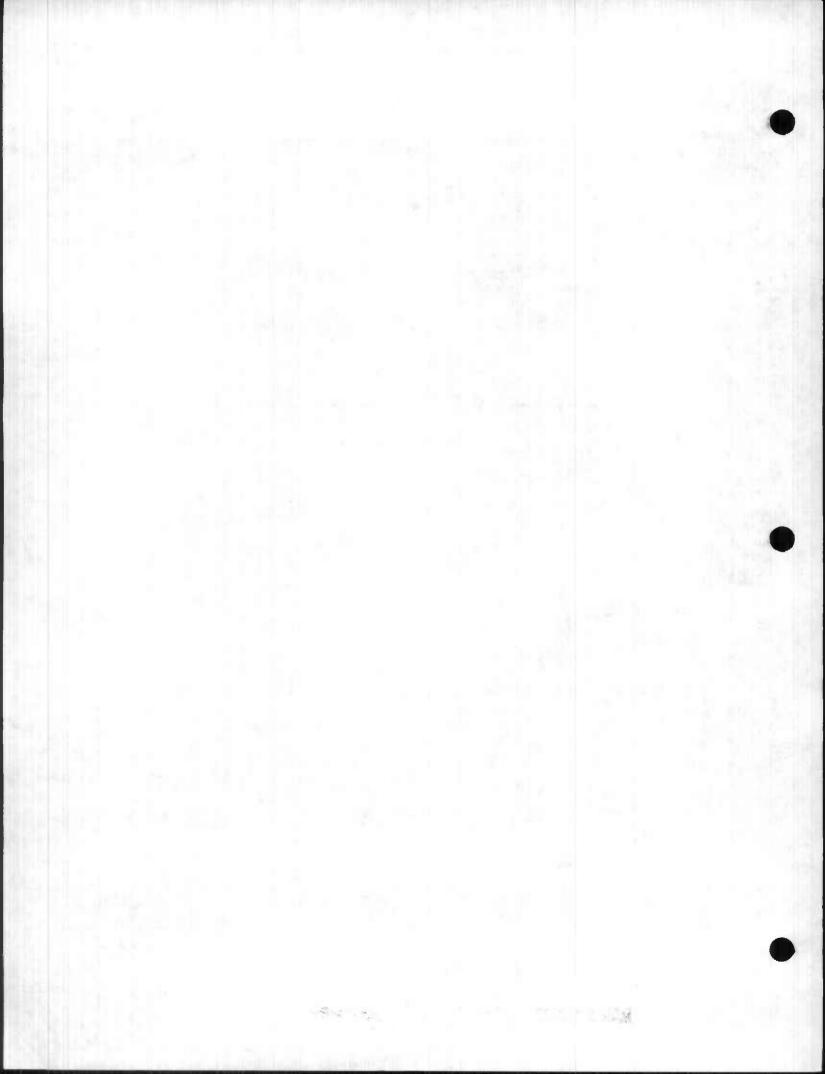
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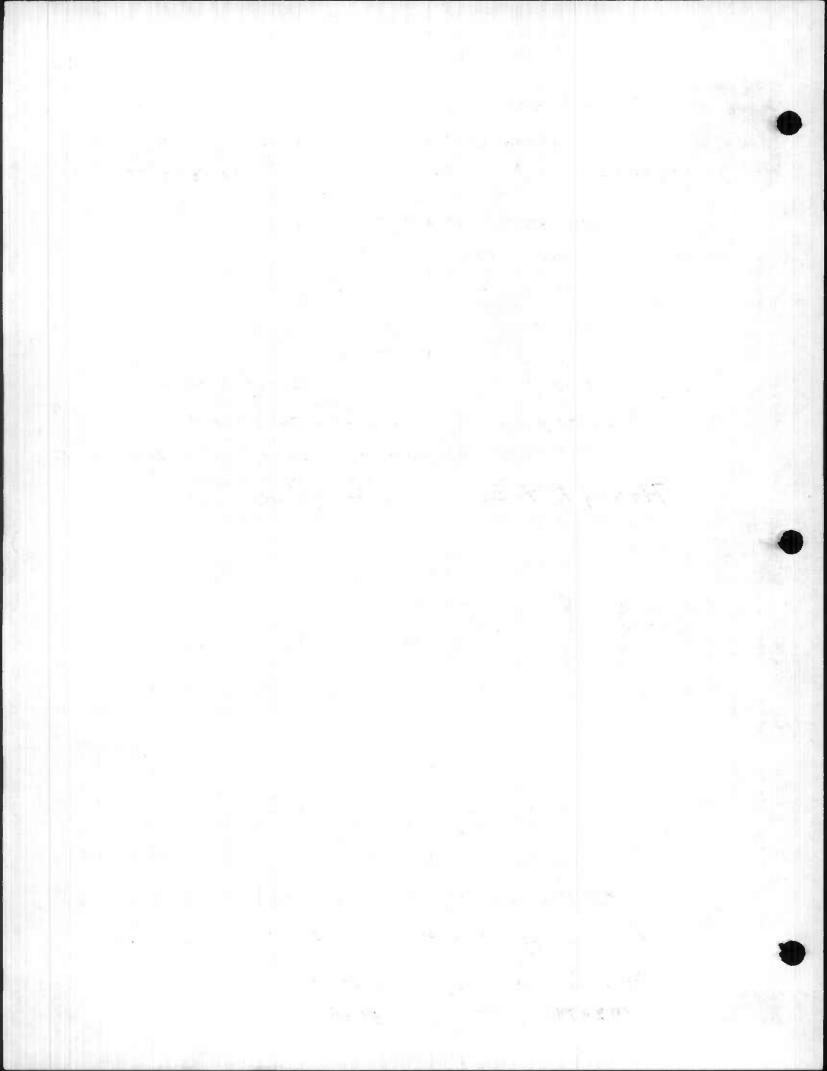
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dost count Funeral	11, Maritel Status	12. Wes Decedent Ever in U. Armed Forces?	,S. 13. V	Nas Decede f Yes, specif	ent of Hi fy Cube	ispanic Orig n, Mexican	pin? (Sp. Puerto	ecify Yes or No- Rican, etc.)	14. Hac	ck, White,	can Indian, etc.
Y F	1 Never Married 2 Married	1 🕅 Yes 2 🗆 No If Yes, Give		□ Yes 21	☑ No	Specify:			Specify	/: ·	
dby	3 Widowed 4 Divorced	Year or Dates: WW]]			<i>A</i>					White	e
Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual kind of work DO NOT use	Occupa done	ation during most	of work	ina	16b. Kind of B	usiness/Ir	dustry
du	Etementary/Secondary (0-12)	College (1-4or 5+)	life. L								
l o	12			Insta	Llat	ion			C+P Te	elepho	ne Co.
BeC	17. Father's Name (First, Middle, Last)					18. Motha	r's Name	(First, Middle,	Meiden Sumen	ne)	
To	Charles F	ranklin Basil				Mar	y An	na Flood			
p.m.	19a. Informant's Neme/Ralationship (T)	ype, Print)	19b. Maitin	g Address	(Street		-	al Route Numbe	r, City or Town,	State, Zi	Code)
	Dorothy Q. Basil/ W	ife	138	S. Home	elano	d Aveni	ie A	nnapolis,	Md. 2140	)1	
	20a. Method of Disposition	20b. F	lece of Dispos	sition (Nem	e of			Date	20c. Location		own, State
	1 Buriel 2 Cremetion 3 D	Removel from State	emetery, crem			:0)		2 21 00	D . 1	. 7 7	
	4 Donation 5 Other (Specify,		kemont (		-			3-31-00			, Maryland
DCS	2t. Signeture of Funeral Service Licens	0 0	22	. Name end	Addres	ss of Facilit	Jol	nn M. Tay	lor Funer	al Ho	me, Inc.
500	E. Burn	truell		147 D	uke d	of Glou	icest	er Street	Annapol	is, M	aryland 2140
	23a. Part1. Enter the disease, or comp shock, or heart faiture. List only of	olications that caused the deat	h. Do not ante	ar the moda	of dyin	g, such as	cardiac	or respiratory er	rast,		Approximate tnterval Between
an							11.70	4.		1	Onset and Death
al	Immediata Causa (Finat disease or condition	Mya	raint	1	T	INTO	à V	Livu			Dume.
er	resulting in death)	a. Myor Due to 10	Taca concen	( w)		- 4 (   0				1	
ē III		600000	112.0	1	Th	PINCE	-10	icu Cis		1	Ynr
Examiner			er es e conseq		/ /1	-	-/-	10211			113
Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	000 (0 (0	i es e conseq	derios oi).							
<u>e</u>	Cause (Disease or Injury thet Initiated events	C		unnen eft.						-	
edical Examir	resulting in death) Last	Due to (o	r as e conseq	uence or):							
2		d									
- Ja											
Physician/	Part II. Other significant conditions co	entributing to death but not ras	ulting in tha ur	ndarlying ca	use give	en in Part I		23b. Did 1	obacco uss co	intributa 1	to the cause of deati
Ph								10	Yss 2 No	3 Pro	bably 4 Unknow
by										T	
-									an autopsy rmed?	a	ara autopsy tindings vailable prior to
ted										0	omptation of cause death?
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ompleted t								10)	es 2 No	1	Yas 2 No
Completed	25. Was case reterred to medical					26 Diago	of Doot	1 🗆 \		1	☐ Yas 2☐ No
Be Completed	25. Was casa referred to medical axaminer?	Hospital:	5010		Oth	or:		h (Check only o	ne)		
To Be Completed	axaminer? 1 Yes 2 No	1 Unpatient 2 U	ER/Outpatien		A	er: 4 🗆 Nu		h (Check only o	ne) denca 6 Ott	ner (Spec	
To Be Completed	axaminer? 1 □ Yes 2 □ ₩0  27. Manner of Death 1 □ Natural 5 □ Pending	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Dey Year)	ER/Outpatien 28b. Time of injury	28	Bc. Injun Worl	er: 4□ Nu yat k?	rsing Ho	h (Check only o	ne) denca 6 Ott	ner (Spec	
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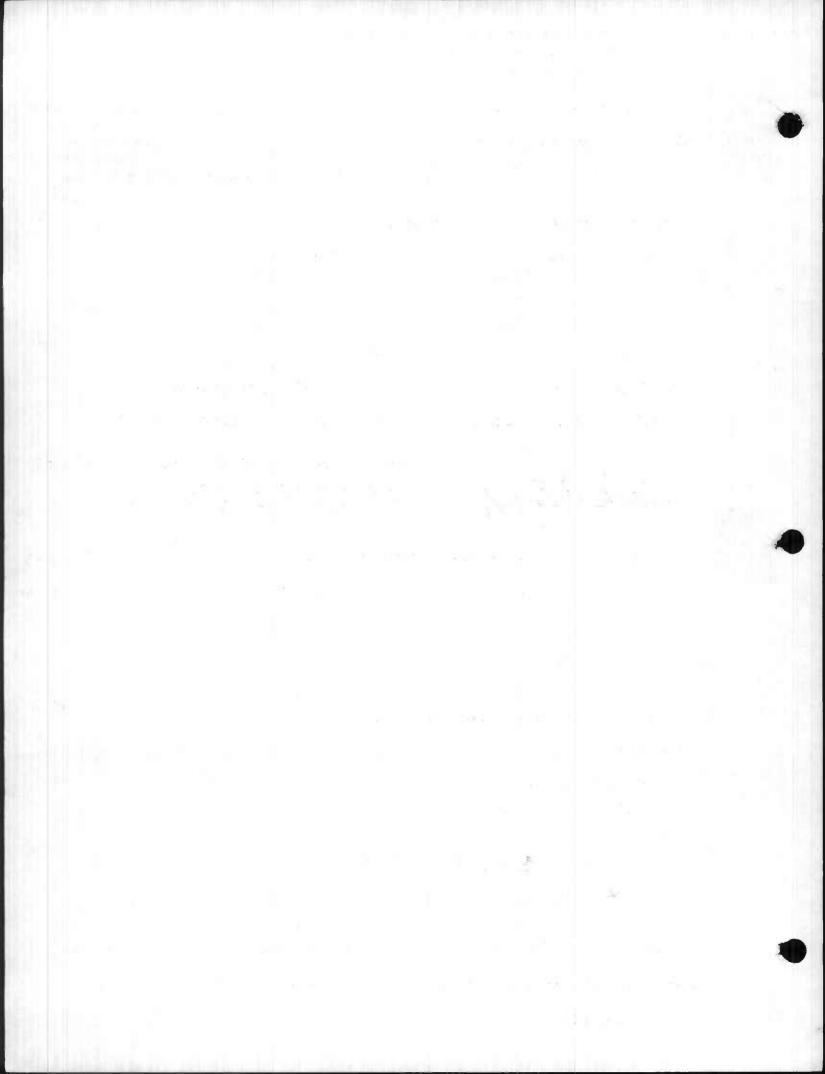
State of Maryland / Department of Health and Mental Hygiene 1 191

				Certificate of	Death	Reg. N	00 1	1940
Physicia	an	1. Decedent's Name (First, Middle, Last)	4			Date of Deeth Month D	ey Year	3. Time of Dea
/Medica	al	Ida Bryan					22 200	
Examine	er	4a. Facility Neme (If not Institution, give street ar			4b. City, Town, or Location		c. County of Dea	
Comment	-	5. Social Security Number 6. Sex	7. Age (In yrs. last bi		If Under 24 Hrs. 8, [	Date of Birth	WICOM	
Funeral Director		579-24-92/4 1□M 25 Usual Residence of Decedent	F 92	Yrs. Months Days	Hours Min. (	Month, Day, Year 03-23-0	7	thpleca (State or For ountry) YLAND
Mow #		10a. Stete 10b. County	10c. City, Tov	wn or Location				10d. Inside City Lir
Alfand .	ctor	MARYLAND ANNE ARUNI	DEL GLEN	BURNIE				Yos 2□
or 2	Director	10e. Street end Number		10f. Zip Code			itizen of What Co	ountry?
23		6469 GRAFTON GARTH		21061			SA	
o'd	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U,S. ed Forces? Yes 25 No s, Give or Dates:	13. Was Decedent of H If Yes, specify Cub	dispenic Origin? (Specify en, Mexicen, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Ame Bleck, White Specify: BL	te, etc.
netural',	Completed	15. Decedent's Education (Specify only highest grade comple	16s	a. Decedent's Usuel Occup (Give kind of work done	pation	16b.	Kind of Business	/Industry
	npidu		ge (1-4or 5+)	life. DO NOT use retire	d)			
Hygiel ther ti		12th 0		HOMEMAKE			NONE	
E C E	Be	JOSEPH BROWN			18. Mother's Name (Fir			
marks marks	2	19a. Informant's Name/Relationship (Type, Print	10	h Mailing Address (Street				Zin Cada) a
is is			LAT GREAT	b. Mailing Address <i>(Street</i> ) 6469 GRATF			N BURN	
PES	ľ	20a. Method of Disposition	20b. Place of	of Disposition (Name of	D		ocation - City or	
int: If		MB Burlal 2 Cremation 3 Removel 4 Donetion 5 Other (Specify)		OLIS MEM.	GARDENS 3,	/27/00	ANNAPO	LIS, MD.
Departn Importa any Inju		21. Signature of Funeral Service Licensee	lese		& SONS MO			01
		23a. Part1. Enter the disease, or complications to shock, or heart feilure. List only one cause	hat ceused the death. Do on each line.					Approximate Interval Between
nysician				_				Onset and Deat
Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a.	Exebrovas Cul	lar accid	ent			" day
Heren.	_	Tooling it doubly	Due to (or as a	consequence of):				
nsit		b	pricumoni	, 4				1days
e ettending physician and od for use as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.	Due to (or as a	consequence of):	/ /		was la	
physician and s the buriel-transit	Medical	Cause (Disease or Injury that initiated events	Hyperiens,	consequence of):  Consequence	os clarotic	carac	Lain	several y
as th	2	resulting in death) Last	disease wis	ts history	of congesti	of Keuri	Dance	Several
for use	2	d	hronic ous	structive pu	umonary	diseas	0	Year
ed for	Physician	Part II. Other significant conditions contributing	to death but not resulting	In the underlying cause giv	ren in Pert I.	23b. Did tobacc	o usa contribute	to the cause of de
igned by the e	Ž.	3 200 200 200 200 200 200 200 200 200 20	•		254,00 9117	1 Yes	2□ No 3□ P	robably 4214fik
o o	ò							-
been si	9					24a. Was an auto performed?	opsy 24b.	Were autopsy findir available prior to
hes by	Completed							completion of ceuse of deeth?
pege pege	0					1 ☐ Yes	I No	1 Yes 2 No
ertific ector,	P	25. Wes cese referred to medical examiner?			28. Place of Deeth (Ch	eck only one)		
his di		1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/O	-	4 Privirsing Home		_	cify)
ther the	0			Time of lnjury 28c. Injury Wor		Describe how inju	iry occurred	
death.	Cat	2 Accident investigation 3 Suicide 6 Could not be	Naca of Initial At home for		Yes 2 No	agetion (Otmoto	nd Mumber on C	unal Causta Museb - a
Director:		4 ☐ Homicide determined 286. F	Place of Injury - At home, fa uilding, etc. (Specify)	arm, street, factory, office		City or Town, Star		ural Route Number,
Etaly filled		29a. Cartifier 1 Cortifying Physician: To	the hest of my knowledge	e death occurred at the tir	me date and place and o	lue to the cause/	and manner or	etatad
he Funer pletely fil	50	(Check only 2 Medical Examiner: On the	ne besis of examination en menner stated.	nd/or Investigation, in my o	pinion, death occurred at	the time, date ar	d place, and due	to the ceuee(s)
within 24 hours efter deat To the Funeral Director; completely filled in by the	ψ Σ	29b. Signature and title of cartifier		29c. Licens	e nymber	29d. D	ete signed (Mont	h, Day, Year)
> = 0		In I the	sego m.		1001		/	
	-	30. Name and address of person who completed	Cause of death (Itom 22a)	(Type Print)		1		
		PO BOX 2012 S.1	Shuy M	(1) 2/P/2 2-1	2018 DR	Tan	2 #	Wanz
State		31. Date filed (Month, Day, Year)	2 Registrar's Signature	1 4002 -	.c ok	1-11	~ //	20 210
Registrar	-	MAR 2 8 2000	Special /	9. Sparks				
		LUUU						



State of Maryland / Department of Health and Mental Hygiene

			1 December 1 Nove (Fire Mid to 1	State of Ivial	-	Certificate o			Reg. No.	0 11949
	Physic	ian	1. Decedent's Name (First, Middle, Last					2. Date of Dec Month	ath Day	Yaar 3. Tima ot Death
<	/Medi	cal	Alexis Danie		er			MARSH	1	2000 11:59 PM
$k_{\perp}$	Exami	ner	4a. Facility Name (If not Institution, give				4b. City, Town, or		4c. County	of Death
_			JOHNS HOPKINS B				Balti	-		
ı	Funeral Director			M 200/F 7. Aga (	In yrs. last birtho	Months Day	s Hours Min.	(Month, Da	h y, Year) 29 2000	9. Birthplace (State or Foreign Country)  MARYLAND
	yland	l a	Usual Rasidance of Decedent  10a. State 10b. County	1	0c. City, Town o	or Location				10d. Inside City Limits
	Ma-f.s	Director	Maryland Harford	i	Stre	et				1 □ Yas 20 No
	it to	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	8th w	rai	1257 Trappe Road				154			SA
020	72 hours efter deeth with the Manyland natural; or items 23s or 28s-f show other must be notified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorcad	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U,S.	13. Was Decedent of It Yes, specify Cu 1 ☐ Yes 2 ☑ N		Specify Yas or No to Rican, etc.)	14. Rac Blac Specify	e - Amarican Indian, kk, Whita, etc.
Ŏ-IO	2 ho	ted	15. Decedent's Edu	cation	16a. D	ecedent's Usual Occ	upation		16b. Kind ot Bu	usiness/Industry
21215-0020	c 4	Completed	(Specify only highast grad	Collega (1-4or 5+)	(C)	Giva kind of work don fa. DO NOT use reti	le during most of wo red)	rking		
N			17. Father's Name (First, Middle, Last)			N/A	10 Methodo No	me (First, Middla,		N/A
Maryland	S tab S	Be C	David Alan Cooper					eth Ann		16)
Z	d 2 should h and Men 7 is marke traumatic	2	19a. Intormant's Name/Relationship (Ti		19h. N	Mailing Address (Stre				State Zin Code)
	コモトラ		Elizabeth Ann Cox			3 Old Sca				, ,
Baltimore,	- 755		20a. Method of Disposition		20b. Place of D	isposition (Name of crametory or other p		Date	•	City or Town, Stata
E	Peges nent of I nrt: If ite		1 Buriai 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	tamoval from State				4-1-00	Dawling	ton Margaland
alti	교 등 문문		21. Signature of Funeral Service Licens		Dalli	ngton Ceme 22. Name and Add	rass of Facility			ton, Maryland
m	Depa Impo any I		Manuel (1.0	meet		McComas	Funeral H	iome, P.A	١.	
IL			23a. Part1. Enter tha disease, or complishock, or heart failura. List only of	ications the caused the	a daath. Do not	enter the moda of d	ying, such as cardia	c or respiratory a	rest,	Approximata Interval Between Onsat and Death
	Physician /Medical Examiner	iner	resoluting in death)	RESPIRATION DU	e to (or as a cor	nsequence of):		as labst	ATION	18 1/2 HOURS
Box 68760,	n certificate be executed inding physicien end use es the buriel-transit	n/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	Du	e to (or as a cor	nsequence of):				
	or itte	sicia	Part II. Other significant conditions cor	ntributing to death but r	ot resulting in th	ae underlying cause (	siven in Part i	23h. Did 1	obacco use co	ntribute to the cause of death?
<u> </u>	es thet the de igned by the a be detached t	by Physician/M	SUSPECTED INTO							3 Probably 4 Vinknown
Vital Records,	sw requir	Completed b	ANEMIA						an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
<b>E</b>	The ate h	Con	THROMBUCYTOPEN	) A				1 🖾	as 2□No	1 ☐ Yas 2 ☐ No
Ita	ysician: The s certificate director, pag	Be (	25. Was casa raterred to medical examiner?				26. Place of De	ath (Check only o	ne)	
ot	00	2	1 ☐ Yes 2 ☑ No	lospital:	2 ☐ ER/Outpa	atient 3 DOA	ther: 4 Nursing I	lome 5 Resid	lanca 6 Oth	er (Specify)
noi	afing After fune	atlon:	27. Manner of Death  1 ☑Naturai 5 ☐ Pending  2 ☐ Accidant investigation	28a. Date of Injury (Month, Dey Yo	ear) 28b. Tim inju	ry W	uryat ork? □Yes 2□No	28d. Describe h	now injury occur	red
=	는 는 는 은	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28a. Place of injury building, etc. (5	- At homa, tarm Specify)	, street, factory, office	a	28t. Location (S City or Tox		er or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (	29a. Certifier (Check only one) Certifying Phys	sician: To the best of m ner: On the basis of ex and mannar stated	amination and/o	eath occurred at the r Investigation, in my	time, date and place opinion, daath occu	a, and dua to tha ourrad at the time,	causa(s) and ma date and placa,	nner as stated. and dua to tha cause(s)
	within 2 To the comple	Me	29b. Signature and title of cartifier			29c. Lica	nsa number		29d. Data signa	d (Month, Day, Year)
			Mark Damion 2	him mo		Do	0029866	0 1	MARCH 3	0 2000
		- 1	30. Name and addrass of person who co							
			MARK DAMIAN H			5 HOPKIN	S BAYUIE	WMEDI	CAL CE	NTER
	Sta	te	31. Data tiled (Month, Dey, Year)	32, Registrar's	Signature	4 /	1			



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) AMEND# 31 AACO Health 4/3/2000 cmh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0=30PM layton 0 Norcia /Medical 4e Facility Neme (If not institution, give street and numb 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Munder 2 Hrs. 8. Date of Birth Anne Arundel e 8. Date of Birth (Month, Day, Year) April 3, 194 If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 10M ADF 50 220-52-5055 Director California Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 💢 No Directo Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 506 Hilltop Lane 21140 United States Funerai Rems 2 Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Black, White, etc. 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☑ Married 21215-0020 "naturel", or 1 Yes 2 No Specify: py 3 Widowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame Baltimore, Maryland 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumame) . Pages 1 and 2 should be fill transfer of Health and Mentel Hant: If item 27 is marked off jury or other treumstic even Be Gerard J. Ciccarone Mary M. Campbell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Randall S. Clayton/ Husband 506 Hilltop Lane Riva, Maryland 21140 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlat 2 Cremation 3 Removal from Stete
4 Donation 5 Other (Specify) Department of Important: If eny injury or 04-06-00 Brentwood, Maryland Ft. Lincoln Crematory 21. Signeture of Funeral Service Licer 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Be Completed by Physician/Medical Examiner serten SION The law requires that the death certificate be executed anding physician and usa as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Lest Due to (or as a consequenca ot) Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, 24b. Were eutopsy findings available prior to 24e. Was an autopsy performed? Exogram Obesity completion of cause of death? 2 0 No 1 Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28d. Describe how injury occurred 27. Menger of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 1 (DNatural 5 Pending investigation 28e. Place ot Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 3 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

State Registrar 31. Date tiled (Month, Dey,

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oumpleted cause of deeth (Item 23a) (Type, Print)

>- Avatum, MO, PhD

32. Registrar's Signature

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645 Baitiman Annopais Blod #105 Seven Park, MO 21146

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** ANNE MARYLAND CIVITARESE 39,2000 4:05 AM MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1/EN BURNIE If Under 24 Hrs. 3. Date of Bi ANNE ARUNDEL ARUNDEL HOSPITAL If Under 1 Year 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2X F Ves 216-16-8214 AUG. 28, 1922 VIRGINIA Director **Usual Residence of Decedent** r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be n Norris 23s 500 ST. MARTINS LANE 21146 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 12 **OPERATOR** TELEPHONE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental unt: If Nem 27 is marked or STANLEY McCREARY CLAUDIA BRAXTON 19a. Informant's Name/Relationship (Type, Print) (HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES PAUL CIVITARESE 500 ST. MARTINS LANE, SEVERNA PARK, MD. 21146 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MARCH 31 XX Burial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) BROOKLYN PARK, MD. 2000 21. Sign Hum of Funeral Service Licenses 22. Name and Address of Facility any ir SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part 1. Enter the disease, of commentations that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MUDCARDIAL INFARCTION Examiner Examiner burial-transit The law requires that the death certificate be assected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760, Physician/Medical Due to (or as a consequence of) US0 08 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably Unknown Records, Aq pege 2 ahould b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy this cartificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Division To the Hospital or Attenuors within 24 hours after death. To the Funeral Director; After a control of the further of the furth 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Miscol certifier MU 14397 March 29 2000 of person who completed cause of death (Item 23a) (Type, Print) everingi. 301 Hogetz Devil Brume .400. 21061 Moke 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2000 1 Freeze Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death APRIL Myron Elbert Dade 2:000 01 4a Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 1 Months | Day HOME NURSING-HARFURD CITIZENS GRACE 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, XXM 2DF Months 214-16-3917 97 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Port Deposit 1 Yas 200 No Cecil Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 U.S.A. 91 Honevsuckle Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2000No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yaa or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married 1 Yes 2 X No Specify: Specify. White 3€Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Immaculate Heart of Mary Elementary/Secondary (0-12) Collage (1-4or 5+) Church Plumber Three Years Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Margaret Sharkey Henry Dade 19a. Informant'a Name/Relationahlp (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 91 Honeysuckle Drive, Port Deposit, Maryland 21904 Charles L. Burkart 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Ramoval from Stata Holly Hill Memorial Gardens 4/4/00 White Marsh, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. tatterson, Sr. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disaase or condition resulting in death) Mic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death 1 Yaa 2 No 3 Probably 4 Whiknown 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 2 1 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Plage of Deeth (Check only one) examiner? Other. 4 Nursing Home 5 Residence 6 Othar (Specify) 20 No 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Deacribe how Injury occurred 28c. Injury at Work? 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide

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P.O. Box 68760 Records, Division of Vital To the Hospital of within 24 hours a To the Funeral D

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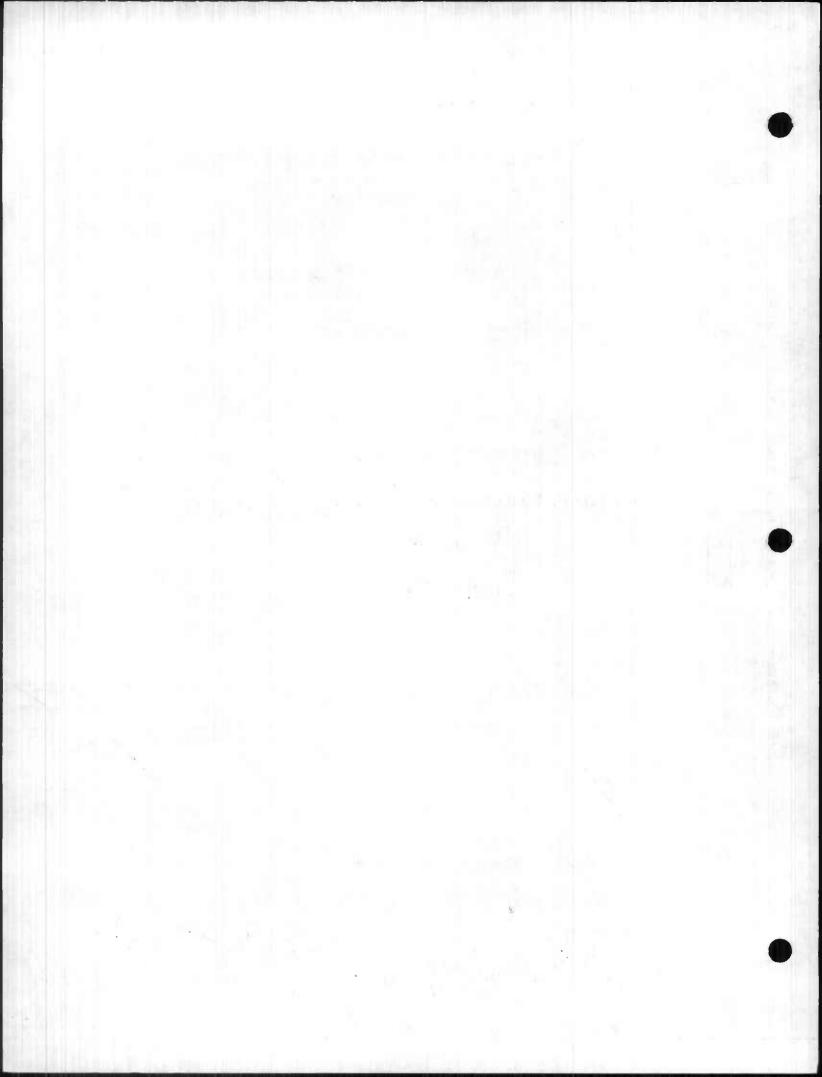
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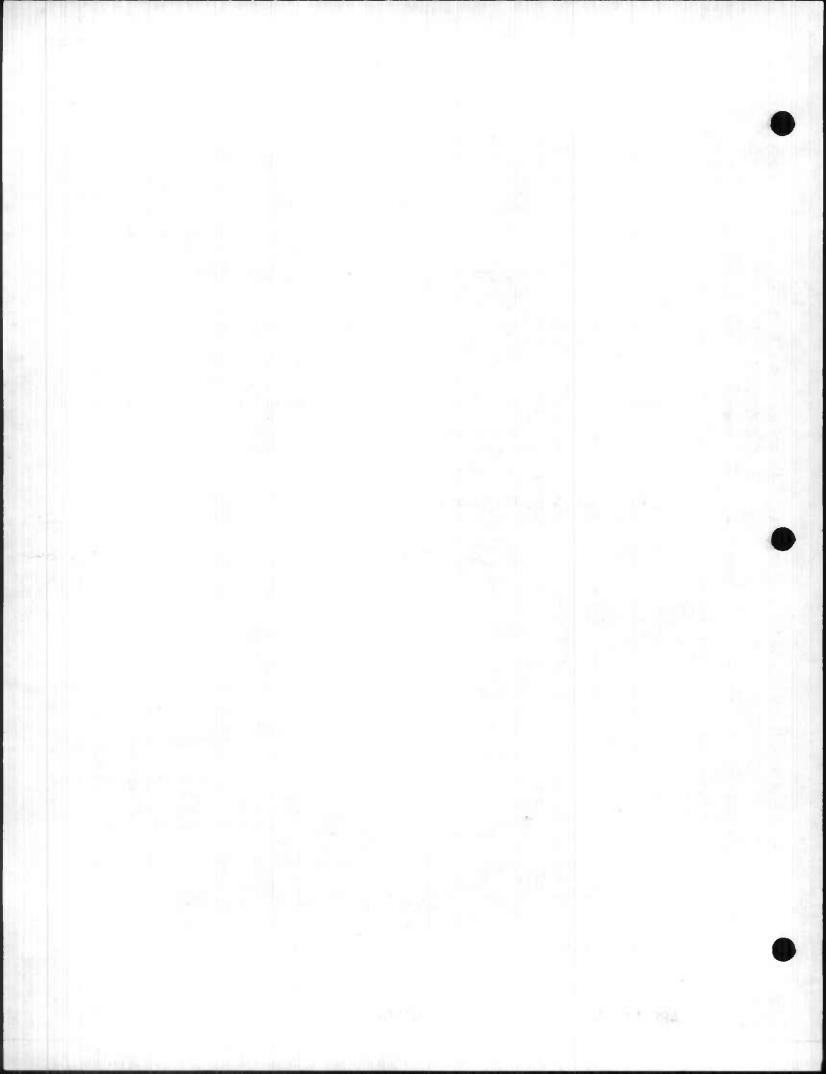
1th Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and memory as season 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. Ligense num

ntt, Day, Year)



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Dis 1 1 1	1. Decedent's Nama (First, Middla, Li	est)						2. Data of Dea Month	th	Voor	3. Time of Death
sician edical	Mae	Jessie DiG	iovanni					April	$\overset{\text{Day}}{2}$ , 2	2000	1615
niner	4a Facility Nama (If not institution, gir							ation of Death	4c. County		
	Laurelwood Nu						1ktor				cil
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	Usual Rasidance of Decedant  10a. Stata 10b. County		10c. City, Town o	or Location						1	Od. Inside City Limits
Director	Maryland Ceci					ryvill	.e				1 XYes 2 No
ral Dir	10e. Street and Number 345 Broad Street,	Apt. No. 3	3	10f. Z	ip Code 2	1903			10g. Citizen of \	S.A.	ntry?
by Funeral	11. Meritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent E- Armed Forces? 1  Yas 2 No If Yas, Giva Yaer or Detas:	ver in U,S.	13. Was Dec If Yes, sp 1 ☐ Yes			gin? (Spec , Puerto R	ify Yes or No- ican, atc.)	14. Rac Blac Specify	ck, Whita,	en Indian, etc. hite
ete	15. Decedent's E (Specify only highest gr		16a. D	ecedent's Us	ual Occu	pation during most	of working	,	16b. Kind of B	usiness/In	dustry
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ToB	Howar	d Hipkins					Er	nma Bak	er		
-	19a. Informant's Name/Ralationship	Type, Print)	19b. N	failing Addres	s (Stree	t and Numbe	or Flural	Routa Numbe	r, City or Town,	Stata, Zip	Code)
	Viola M. Owens (D	aughter)	344	Jacks	on S	tation	Road	d, Perr	vville.	Mar	yland 2190
	20a. Mathod of Disposition		20h Place of D		ama of			Data	20c. Location -		
	1 ☐ Burial 2 ☐ Cremelion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			rin Ce			14	77/00 H	lavre de	Gra	ce, Maryla
	21. Signature of Funeral Service Lice		110. 1			ess of Facilit		7,00 41	avic de	. Ola	ce, naryra
300	23a. Pan1. Entar tha disaase, or con shock, or haan lailura. List only	()	x.Sr.	Tee A	Pa	ttersc	n & 9	Son Fun	eral Ho	ome,	P.A.
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Completed by Physician/					_			24a. Was a perfor	an autopsy med?	av co	ere autopsy findings allable prior to impletion of cause death?
PO								1 U Y	es 2ENo	1[	☐Yes 2☐No
Be	25. Was casa ralarred to medical examinar?					26. Place	of Death	(Check only or	ne)		
To	1 Yas 2 No	Hospital: 1 Inpatien	t 2 ER/Outp	atient 3 0	OA Ot	her: 42 Nu	rsing Hom	a 5 🗆 Resid	ence 6 Oth	er (Specif	(y)
	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accidant invastigatio	28a. Data of Injury (Month, Day	Year) 28b. Tirr		28c. Inju Wo 1	nyat nk? ]Yes 2 □ l		d. Describe h	ow injury occur	red	
Certification:	3 Suicide 6 Could not be detarmined	28a. Place of Injur building, atc.	y - At homa, farm (Specify)	, streel, facto	ry, office		28	8f. Location (S City or Tow		ber or Run	al Routa Number,
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	30. Nama and addrass of person who	complated causa of de	ath (Item 23a) (T)	pe, Print)		1 121					
	Monte Makou	5 111 h	1. High	1>+	E	1 Ktor	N	10 0	21921		
State	31. Dete liled (Month, Day, Year)	32. Registrar	's Signatura	and.	,						



State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 1 2000 1840 P Verona Eleanor Dill April /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Union Hospital If Under 1 Ye If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🛛 F 221-16-7425 Director 74 SEPT 16, 1925 Maryland Usual Residence of Deceden the Manylend 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 XYes 2 No Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 21921 United States Funeral 110 Normira Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours effer Hygiena. Ther than "natural", or ite 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: à 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hyglen. Important: if item 27 ie marked other that any injury or other traumatic event, the back. 10 Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be George Sprout Theresa Logan 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley A. Reeder/Daughter 727 Dr. Miller Road, North East, MD 21901 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State etery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill Methodist Cem 4/5/00 Cherry Hill, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 19 lanias Examiner Due to (or as a consequence of): Examiner physicien end the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee > No 3 Probably 4 Unknown bengis be de p of Vital Records. Ą 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 24 hours after deeth. e Funeral Director: After this certifical letely filled in by the funeral director, 25. Wes case reterred to medicel examiner? 80 26. Place of Death (Check only one, To Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Naturat
2 Accident 28d. Describe how injury occurred of Injury 28b. Time of 28c. tnjury et Work? edical Certification: 5 Pending investigation Division 1 TYes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) ľ waya 30. Name and address of person who completed chase of death (Item 38a) (Type, Print) Barbara Parey, M.D., 111 West High Street, Elkton, MD 21921

Registrar

State

32. Registrar's Signature

All I have

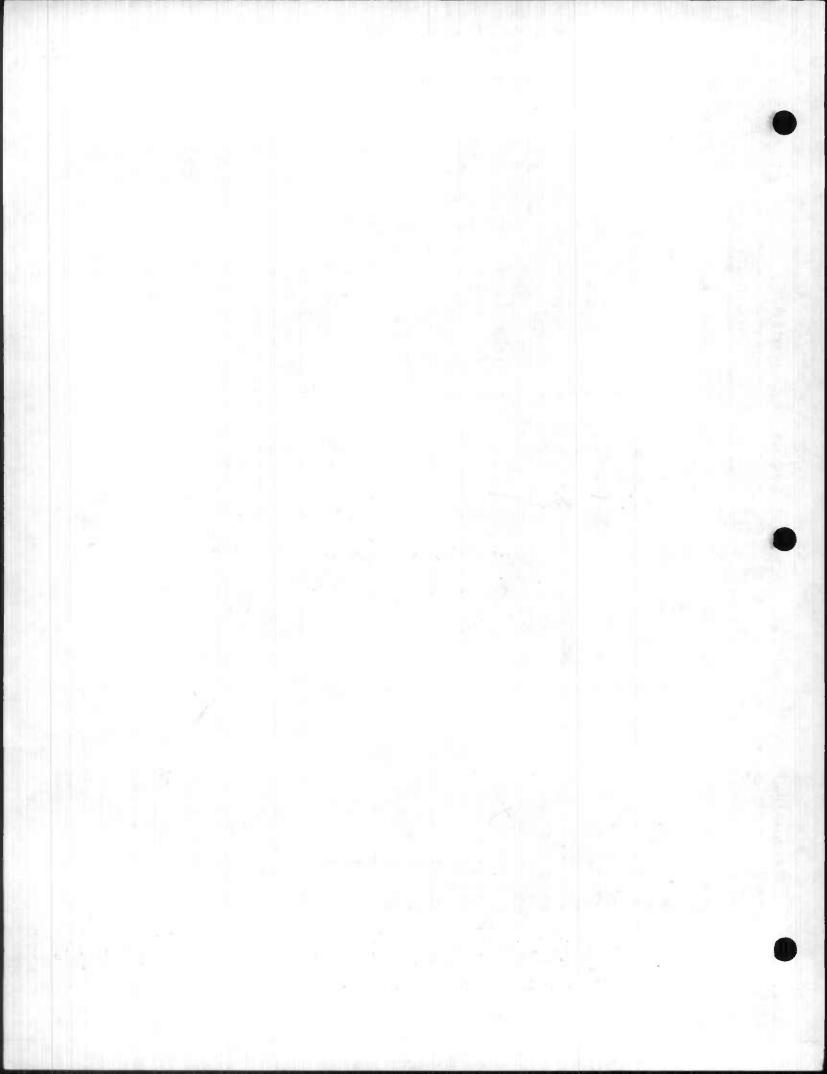
State of Maryland / Department of Health and Mental Hygiene

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Examiner	4e Facility Name (If not institution, g	nive street and number,	)		4	b. City, Town, or Lo	cation of Death	4c. County		
<u> </u>	CIVISTA MEDICAL CE					LAPLATA		CH	ARLES	
Funeral Director	5. Social Security Number 6. 219–58–9617 Usual Residence of Decedent	. Sex 7. Ag	ge (In yrs. last birth	Months	Year Days	Hours Min.	8. Date of Birth (Month, Day May 4 1	, Year)	Count	ace (Steta or F try) consin
pung #	10a. State 10b. County		10c. City, Town	or Location					10	d. Inside City I
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or 28a-f a	10e. Street and Number		0	101. Zip C			1	Og. Citizen of V	What Count	try?
Marie Da	8335 Dean Place	2			20	622		US	SA	
72 hours after death with the Maryland Pattural', or flems 23a or 28a-f show folial Examinar must be notified at ested by Funeral Director	11. Merital Status  1 □ Never Merried 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces?	?	13. Was Decede If Yes, specif	nt of Hi	spanic Origin? (Spen, Mexican, Puerto Specify:	city Yas or No- Rican, etc.)	14. Rac Bled	e - America k, White, e	otc.
ed within 72 hours ygiene. er then "neturel", f. the Medical Ex Completed by	15. Decedent's	Education	16a. E	ecedent's Usual	Occupa	ition		16b. Kind of Bu	usiness/Ind	ustry
	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or		ile. DO NOT use	retired)	luring most of worki )	10			
filled within 72 hours at Hygiene. Hygiene. They can then "netural", or ent, the Wedgel Exam or Completed by E	12			usewife				Own	Home	
s 1 and 2 should be filed within Fleetith and Mental Hygiene. Item 27 is marked other than other treumatic event, the M TO Be COMP	17. Father's Neme (First, Middle, La.	st)				18. Mother's Neme	(First, Middle, I	Maiden Surnarr	10)	
2 should be and Mente la marked eumatic e	Lawrence Greger	son				Marjorie	Kotts	Gregers	on	
d 2 should be flie th and Mental Hy 7 Is marked oth treumatic event	19a. Informant's Neme/Reletionship	(Type, Print)	19b. I	Mailing Address (	Street a	and Number or Rura	l Route Number	r, City or Town,	Stete, Zip	Code)
s 1 and of Health Item 27 other tr	Lawrence P. Dear	(husband)				ce Charlo				
00 - 5	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removel from State		isposition (Name crematory or oth	er pleci	a)	Dete	20c. Location -	City or Tov	wn, Steta
artment of sortant: If Its Injury or o	4 Dogation 5 Dother (Spec	cify)	Trin	ity Memo	ria	1 4-3	-00	Waldorf	, MD	
permit. Pag Department Important: h eny injury o	21, Signature of Faharel Service Lic		173	22. Name and 4433		s of Fecility E te Pls La	berwein White			
	23a Puril. Enter the disease, or co	mplications that cause	d the death. Do no							Approximate Interval Between
rdificate be executed no physician and a set the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	· Joely	GANAMO Due to (or as a co	nadquence of):	SA	مدا سا	Carps	nal	0	
at the death certified by the attending etached for use a Physician/M		d								
the de sched i sched i hysic	Part II. Other significant conditions	contributing to death b	out not resulting in t	he underlying cau	use give	on in Pert I.	23b. Did to	pacco use co	ntributa to	the cause of c
that the de delached detached y							X	ea 2□ No	3 Prob	ably 4 Un
been sign should be							24a. Wes a perfor	in autopsy med?	ava	re autopsy find illable prior to npletion of cau- seath?
The lew ate has b page 2 s							1 D Y	es alano		Yes 2□ No
oertificata rector, pag	25. Wes case referred to medical					26 Place of Death		1 (	, ,	7105 20140
	examiner?	Hospitel: Vanpati	ent 2 ER/Outp	atient 3 DOA	Othe	26. Place of Deeth 97: 4□ Nursing Ho			or (Coocib	d
B 45 0	27. Mapfer of Death  1 Netural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	ary 28b. Tir	ne of 280	c. Injury Work		28d. Describe h			,
949 E	3 Suicide 6 Could not determine	d 286. Place of in	jury - At home, fam ic. (Specify)	n, street, factory,	office		28f. Location (S City or Tow		per or Rural	Route Numbe
he Hospital in 24 hours he Funeral pletely filled edical Ce		Physician: To the best aminer: On the basis o and manner st	f examination end/							
within 2 To the comple	29b. Signature and title of certifier	~ I A		29c.	License	number	2	9d. Date signe	d (Month, L	Day, Year)
F 5 F 0	30 Neme and address of person wh	John	teath (learn 27a) (T	una Print\	D-:	20629		3	31	100
		MD 11345 PEME			WALD	ORF, MD 206	03			•
State Registrar	31. Date filed (Month, Day, Year)		rar's Signature	- /-	,					

DHMH 16 Rev 6/95

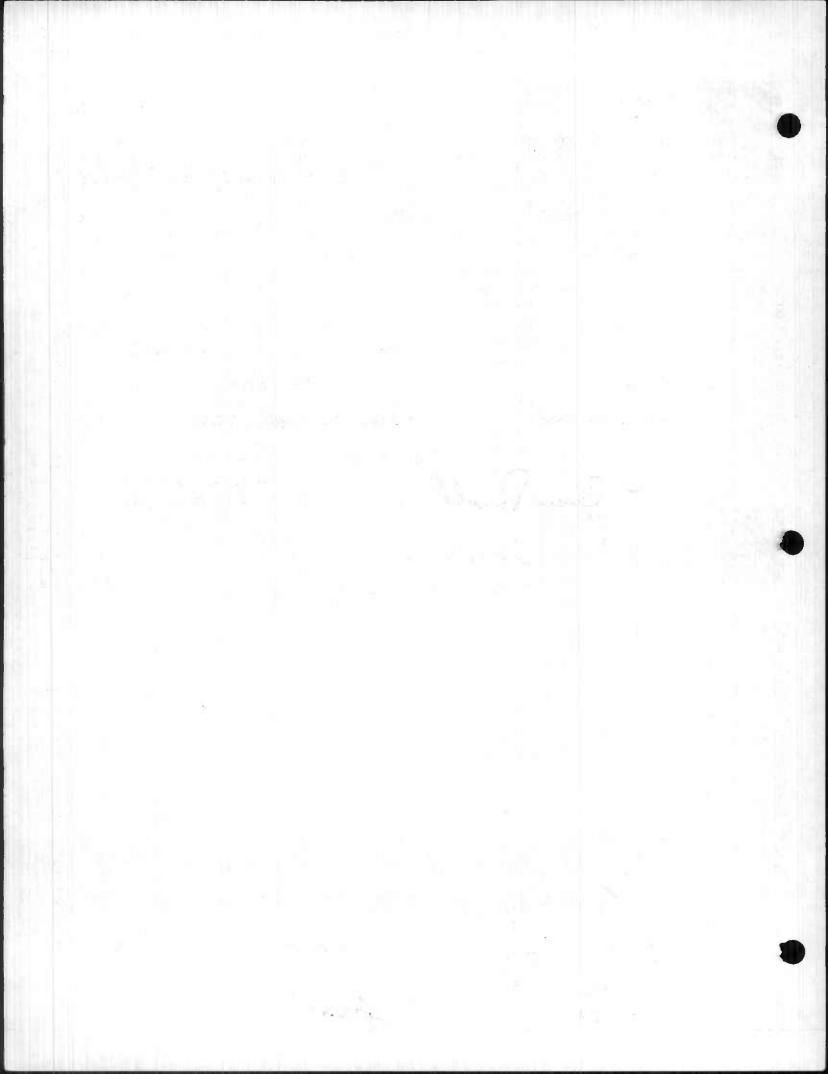
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00

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								Cer	tificat	e of	Death			Reg. No.		
	Physic /Medi		1. Decedant's Nan Cordelia	me (First, Middle, L a	<sub>ast)</sub> Davis								2. Date of De Month March 2	eth Day	Year OO	3. Time of Death
	Exami			(If not institution, gi f Pavillion		umber)					4b. City, To Annapo	_	ocation of Death	4c. Count	y ot Death Arunde	
	Funeral Director		5. Social Security  none Usual Residence		Sex 1□M 2□xF	7. Age	(In yrs. lest birti	nday) 'rs.	If Under Months	1 Year Days 5		24 Hrs. Min. 30	8. Date of Bir (Month, Da Feb. 20,	y, Year)		place (Stete or Foreign ntry) yland
	the Maryland 28a-f show	tor	10a. Stete	10b. County Anne Arun	del		10c. City, Town								1	10d. Inside City Limits
	a with the	Funeral Director	10e. Street and Nu			1			10f. Zlp	Code 2140	)1			10g. Citizen of	What Coul	ntry?
020	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or items 23a or 23a-f show ther, the Madical Examines must be notified at	by	-	riled 2 Married	12. Was Dec Armed F 1  Yes If Yes, G Yeer or I	orces? 2 🙀 No live		lf lf	/es Deced Yes, spec	ify Cub	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	- 14. Re	ice - Americ ack, White, ity: Whi	etc.
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours to perment of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", any injury or other traumatic event, the Madical Example.	Completed	(Spe	15. Decedent's E acify only highest gr condary (0-12)	ducation ade completed, College			(Give I life. D	ent's Usua kind of wo O NOT us ONE	rk done	during mos	st of work	ing	16b. Kind of E		dustry
Maryland	should be filed with nd Mental Hygiena. merked other than umatic event, me.M.	To Be	17. Fathar's Neme Alden Day	(First, Middle, Las VIS IV	t)								e (First, Middle, Freinek	Maiden Suma	me)	
	1 and 2 sho Health and 1 em 27 is me		-	Name/Ralationship Davis / Mot									el Route Numb S, MD 214		n, Stata, Zip	Code)
Baltimore,	permit. Pages 1 a Depertment of Hei Important: If item any injury or othe			sposition Cremetion 3 [ 5 ☐ Other (Speci		State	20b. Place of cemeter, St. Mary	, crem	etory or o	ther ple	oce)	Me	Date er.30,'00	20c. Location Annapoli		own, State
Balt	pemit. Page Depertment of Important: If any injury or once.		21. Signature of F	unerel Service Lice	nsee	)	20						n M. Tayl St. Annap			e, Inc.
ž	death certificate be executed  Example 1	ian/Medical Examiner	Immediate Causa disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mmediate errying r injury	a.	D	whe must of the control of the contr	onsequ	ence ot):	ity	psis					Onset end Death  2 days  3 days
	is that the d gned by the se detached	by Physician	Part II. Other signi	ificant conditions	contributing to d	leath but	not resulting in	the un	derlying c	ause gi	ven in Pert	l.		obacco use co Yes 2⊠No		the cause of death bably 4 Unknow
Hecords,	aw requi	Completed											24a. Was perfo	en eutopsy med?	av	era autopsy findings allable prior to mpletion of cause daath?
	ysician: The is certificata director, pag	To Be Cor	25. Was case rete examinar?		Hospital: 1	, Vnpatian	t 2 ER/Out	patient	3□ DC	A Ott	nor:		1 Check only of	na)		Yes 2 No
DIVISION	ttending death. :tor: After / the fune	Certification:	27. Mannar of Dea 1 XNatural 2 Accident 3 Sulcide	th 5 Pending investigatio 6 Could not bedatarmined	e one Diese		Yeer) 28b. Ti	iury	М		ryat rk? IYes 2 □	No	28d. Dascribe I			of Route Number,
=	To the Hospital or A within 24 hours effer To the Funeral Directompletaly filled in by		4 Homicide  29a. Certifier (Check only	Certifying Pi	build	ling, etc.	(Specify) my knowledge,	death	occurrad	et tha ti	me, date an	d place,	City or Tov	cause(s) and m	anner as s	tated.
1	To the Ho within 24 To the Fu complets	Medical	29b. Signature age	2 Medical Examination of certifier	end man	D	90.		290 D	. Licens	ppinlon, des			29d. Date sign	ed (Month,	
	Sta Registr	_	31. Date tiled (Mon	4111			's Signature	ledi G.	cal Pa			apolis	s, Md. 21	401		



Bud attending physician for use as the burial s been signed by the should be detach

Jam **Physician** /Medical Examiner P.O. Box 68760, Records, Division of Vitai Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certificately filled in by the funeral director. To the Hosp within 24 hou To the Fune completely fi 25 State

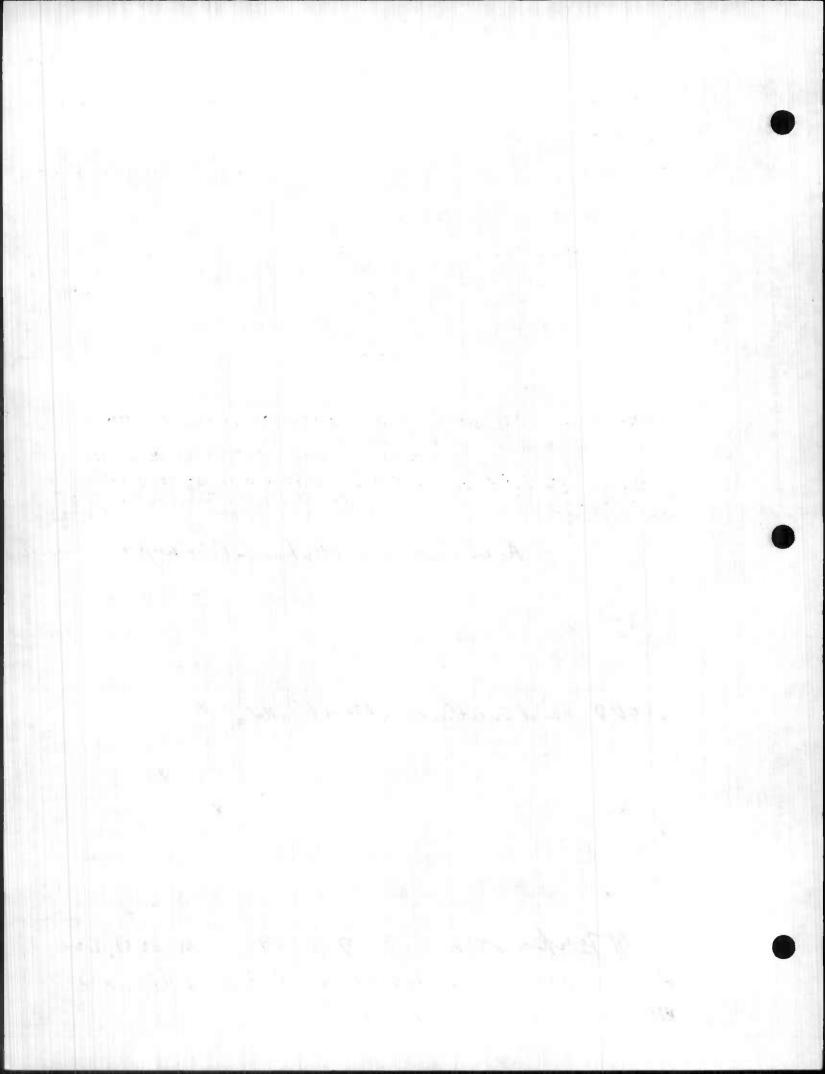
Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Physician March 30 2000 11:40am ADELE KATHERINE FREY /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 132 Buena Vista Dr. Earleville If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year)
Nov 28 1925 9. Birthplece (State or Foreign Country) New Jersey 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months 74 Yrs 154-20-4443 Nov Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 Buena Vista Dr. 21919 U.S.A. Funeral death Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: white Specify: þ 3 2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Education permit Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Nem 27 Ia marked other: 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Willis Treat Bertha Dill 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lizette Bonini (daughter) P.O. Box 456 Cecilton, MD. 21913 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, Stete Data 1 Burial 2 Cramation 3 Removel from Stete Van Liew Cemetery 4/3/00 North Brunswick NJ. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funeral Service License 22. Name and Address of Fecility
Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. or complications that caused the deeth. Do not enter tha moda of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Batwean Onset end Deeth of Unknown Primary site Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hen al Insufficiency, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖄 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Neme and eddress of person who completed causa of death (Item 23a) (Type, Print) n Chesapeche Hospice, Elkton MD -ar/Las

Registrar **DHMH 16 Rev 6/95** 

31. Dete filed (Month, Day, Year)

MAR 3 1 2000

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** Herta Ingeborg Fruhriep March 30, 3:40 AM 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dasth 4c. County of Desth Examiner Genesis Eldercare Center- Spa Creek Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 10M 2XF Hours Min Months Days Director 409-68-1262 68 June 28, 1931 Germany Usual Residence of Decedent the Menyland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f ahow traumstic event, the Medical Examiner must be motified at 1 Yes 2 No Director Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3886 Ponder Drive 21037 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ÀXNo If Yes, Give Yeer or Dates: Race - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer discretiment of Haelith and Mental Hygiena. Introctant: if Nem 27 is marked other than "natural", or Nem eny Injury or other traumatic event, the Handle Exemples. 1 ☐ Never Married 2 Ĭ Married Baitimore, Maryland 21215-0020 1 Yes XX No Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) B Walter Gunther Martha Bromberg 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3886 Ponder Drive Karl F. Fruhriep/ Husband Edgewater, MD 21037 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3-31-00 Alexandria, Virginia Metropolitan Crematory George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signature of Funeral Service Ligensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien end s the burlat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): ettending 880 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No signed by 3 Probably 4 Unknown AMONGKINS LYMPHOMA 5 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peen s pega 2 s has The cartificata a Hoopital or Attending Physician: 24 hours after deeth. a Funeral Director: Atter this carifficiately filled in by the funeral director, 8 25. Was case referred to medical axaminer? 26. Place of Daeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Other: 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manger of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edicai 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. miner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end manner steted. (Check only To the Pwithin 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Bestopte Rd

900

32. Registrar's Signature

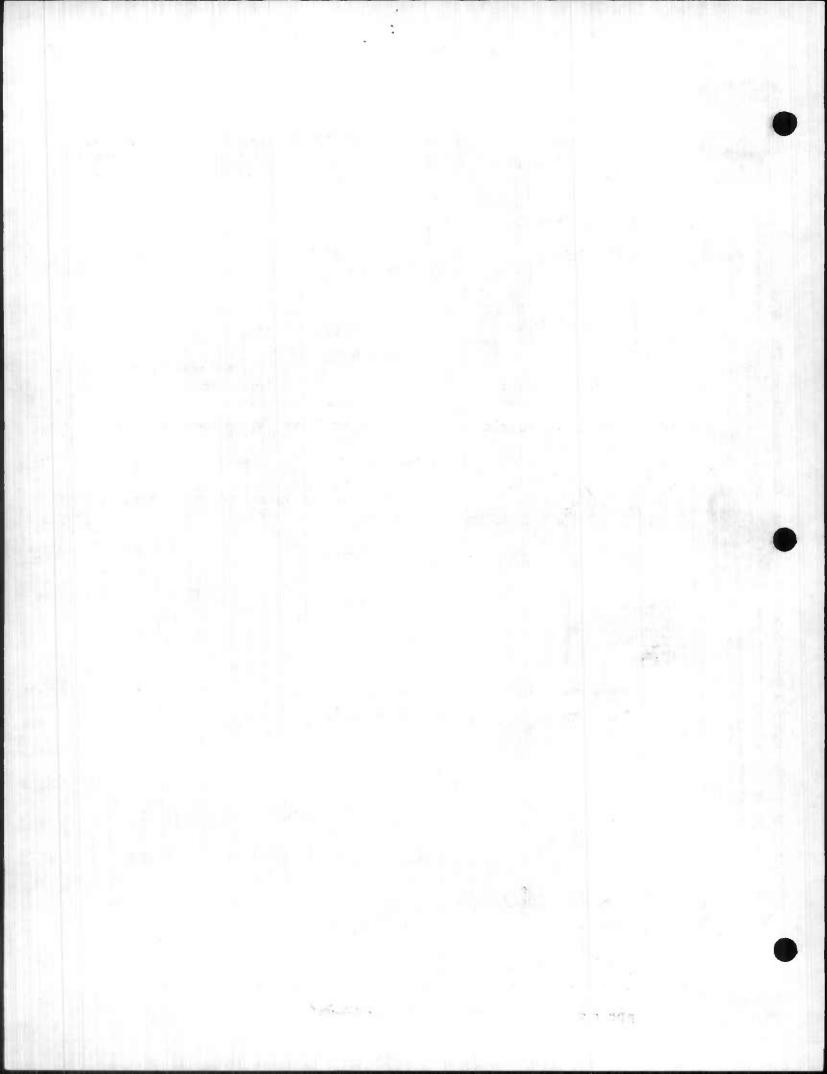
Graze

APR 03 2000

ter

31. Date filed (Month, Day, Year)

#300 Annapolis



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 6:40 P.m **Physician** FRAZIER FRANKLIN D. march 2000 38 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie North Arundel Hospital Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 57 Yrs. 214-40-9426 Director MAY 18, 1942 MARYLAND Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ANNE ARUNDEL MARYLAND GLEN BURNIE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 302 9TH AVENUE, S.E. 21061 Rems 23s U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [] No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 20 Married 'natural', or 1 Yes 2 No Specify: WHITE à Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) ASSISTANT CAR FOREMAN 12 RAILROAD Detail. Pages 1 and 2 should be file.
Department of Health and Mental Montal Intropertant if them 27 is monthly any figury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRAZIER RENA LUTHER MORGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 9TH AVENUE, S.E., GLEN BURNIE, MD. 21061 MRS. MARSHA M. FRAZIER (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3/31/2000 tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK ELKRIDGE, MD. 22. Name end Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Approximate Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? 1 ☐ Yes 2 No 1 TYes 2 TNo or Attending Physician: 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Be To Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Inpatient 2□ ER/Outpatient 3□ DOA 1 Yes 2 No this 27. Manyfer of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Affer 1 Neturel 5 Pending s after death.

I Director: After in by the fundamental in the fundame 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e. Certifier edical (Check only and manner steted. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2000 mi

Registra

**DHMH 16 Rev 6/95** 

21215-0020

Maryland

of Vital Records, P.O. Box 68760,

Division

Burne - MD 21261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Orinna

31. Dete filed (Month, Day, Year)

32. Replytrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** John F.H. Fesq March 27, 2000 9:50 A.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Months 1₽M 2□F Yrs. 144-12-5928 75 Director 1924 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2XXNo Director Maryland Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Coover Road 21401 USA Funeral 12. Wes Decedent Ever in U.S. Amped Forces? 1 ⅓ Yes 2 ☐ No If Yes, Give Year or Dates: W.W. II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Merifel Sfafus permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Nei any injury or other traumatic event, the Medical Examinations. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) R.C.A. Accountant yrs. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 89 Edward J. Fesq Alberta S. Behm 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Natalie N. Fesq/ Wife 505 Coover Road Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery B - 31 - 00Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 will 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical What **Examiner** Due to (or as a consequence of) Examine - Stage COPD the attending physician and hed for use as the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 perver 8 Physician/Medical Due to (or as a consequence of) Chylen P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yes 2 No Probably 4 Unknown Division of Vital Records, P 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Was an autopsy performed? page 2 should Completed certificate has 2000 1 Yes & No 1 Yes 8 25. Was case referred to medical 26. Piace of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 0 3 DOA this o 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Affer Matural 5 Pending investigation death. 2 No 1 Yes 2 Accident i or Attendi after death Director: A 6 Could not be 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide Hospital of 24 hours at To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the fime, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DS MITCHELL AAMC 31. Date filed (Month, Day, Year) 32. Registrer's Signefure State Registrar MAR 2 9 2000

State of Maryland / Department of Health and Mental Hygiene []

1196

				Certifica	ate of	Death		R	leg. No.		
Dhualaian	1. Decedent's Name (First, Middle,	Last)					2	2. Date of Dea Month	th Dey	Yeer	3. Time of Death
Physician /Medical	Rena Frances Ho	oitsma						March	28, 2	000	6:45 pm
Examiner	4a Facility Neme (If not institution, Genesis Elderca	The state of the s		r		4b. City, Too Annap		ation of Death	4c. County Anne		del
Funeral Director	143-28-1528	6. Sex 7. A	ge (In yrs. last birt 84	hday) If Uni Month	der 1 Year ns Days	If Under Hours	24 Hrs. 8	8. Dete of Birth (Month, Day July 10	Year) 1915	9. Birthpi Coun	lace (State or Foreign try) NJ
punt au	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location						11	0d. Inside City Limits
with the Marylan a or 28a-f show the notified at Director	MD Anne Ar	undel	Annap		Zip Code				l0g. Citizen of \	Mhat Coun	1⊠ Yes 2□ No
23s or ust be r	35 Milkshake La	ne			21403				USA		
72 hours after death value is to theme 23s fical Examiner must sted by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces od 1 Yes 2 Hr Yes, Give Yeer or Detes:	?	If Yes, s	cedent of h pecify Cub 2 ₩ No	lispanic Origan, Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No- lican, etc.)	Ble	ck, White, over Whi	etc.
ad within 72 ho ygiene. ser then "nature. I, the Medical. Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12)			Decedent's U (Give kind of life. DO NOT	work done	during most	t of working	0	16b. Kind of B	usiness/Inc	lustry
ygien wer thi	12			Homen	naker				Hon		
Wental H	17. Father's Name (First, Middle, L.  Tunis Van Ho	2.1					na Bar		Meiden Sumen	ne)	
ath and 27 is m	19a. Informant's Name/Relationshi Bonnie Pavlak/D		19b.	Malling Address 315 Du					r, City or Town, Park, MI		
Pages 1 a lent of He mt: If Nem ry or othe	20a. Method of Disposition  1 Burial 2 Cremetion 3 4 Donation 5 Other (Spi			Disposition (f y, cremetory o	or other ple			oril 1	20c. Location		wn, State
Departir Departir Importa any Inju	21. Signature of Funeral Service L	per puro /		22. Name Barra	and Addre	ss of Facilit Sons Ritchi	y P. F	A. Sev	erna Pa	ark Fi	uneral Homo MD 21146
Physician /Medical Examiner	23a. Pefr1. Enter the dissale, or of shock, or heart tailure. List of immediate Cause Final disease or coordion resulting is death)	or piculains that cause by one cause on each t a.	ine.	oot enter the r	node of dyl						Approximate Interval Between Onset and Death
nding physician and use as the burist-transit n/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influsted events resulting in death) Last	c	Due to (or as a o						TY A		
death e sine of for	Part II. Other significant condition	a contributing to death t	but not resulting in	the underlyin	g cause gi	ren in Part I		23b, Did to	obacco use co	ntribute to	the cause of death?
								101	/es 2□No	3 Prot	bebly #SUnknown
The law requires to take has been signe page 2 should be d								24a. Was a perfor		avi	ere autopsy findings allable prior to impletion of cause death?
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certificate nector, pa	25. Was case referred to medical examiner?						of Death	(Check only or	ne)		
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After fune	27. Menner of Deeth  1 Anatural 5 Pending 2 Accident investigs	ition	oy Year) 28b. T	ime of njury M	28c. Inju Wo 1	ryat rk? ∣Yes 2□	No		ow injury occur		
al or Attendes s after death il Director: ad in by the	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of in	ijury - At home, fai tc. <i>(Specify)</i>	rm, street, fac	tory, office		21	8f. Location (S City or Tow		ber or Rure	al Route Number,
Hospit A hour Funer tely fill	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner s	of examination and	, death occurr d/or investigat	ed at the ti ion, in my o	me, date an opinion, dea	d place, ar th occurred	nd due to the d d at the time, d	cause(s) and m dete and place,	enner es s and due to	tated. the cause(s)
within 2 To the comple	29b. Signature and title of certifier				29c. Licens				29d. Date signe		Dey, Year)
	1 200	mene	MO		03	203	6		3/30	00	
	30. Name and address of person S	no completed cause of	death (Item 23a) (	Type, Print)	Dr.	ve C	hert	er MD	3/30	19	
State Registrar	31. Dete flied (Month, Day, Year) MAR 3 1	2000 32. Regist	rar's Signature	B.	1000	de				,	

	1.0	ecedent'a Name	a /First Middle	I est)		Cel	tificate	Of I	Death		2. Date of De	Reg. No.		3. Time of Death
hysiclan Medical		Ja	mes Bri	an Hoecl							March	25 <sup>Day</sup> 20	00 <sup>Year</sup>	1127 am
xaminer		Facility Neme (II 807 Yor)		give street and n	rum <i>ber)</i>				4b. City, To TOWSC		ocation of Deat		y of Death imore	
neral ector		ocial Security N 6-52-56		S. Sex 1 □ M 2 □ F	7. Age (In yrs 45	. last birthday) Yrs.	If Under 1 Months E	Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De Feb. 1	th Year) , 1955	9. Birthp Cour Mary	place (State or Foreign 1(ry) Land
		al Residence of State	Decedent 10b. County		10c. C	ity, Town or Lo	cation						1	Od. Inside City Limits
notified a	Ma	ryland	Baltim	ore		Tows	on							1 ☐ Yes 2 ☐ No
Directo	10e	. Sfreet and Nun					10f. Zip Co	ode			101	10g. Citizen of	What Cour	ntry?
		807 Yor	k Road					212				US		
by Funeral		Marifel Stefus  Wever Merri  Widowed		12. Was De Armed I d 1 Yes If Yes, 0			Wes Decedent Yes, specify		lispanic Ori en, Mexicar Specify:	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	Spec	ack, White,	
eted		(Spec	15. Decedent's	Education grade completes	d)	16e. Deced	dent's Usual C kind of work of DO NOT use i	Occup done	ation during mos	t of work	ing	16b. Kind of	Business/In	dustry
Completed	E	lementary/Seco			(1-4or 5+)		oo <i>wor</i> use nginee		a)			F1	ectri	ral
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	21.	<b>b</b> ///	Mil. I	- 11000		Ğ	eorge I	P.	Kalas	Fur	neral H	ome	\	D 21037
	238	a, Part1. Enter th	ne disease, or c	omplications that	t caused the dea								er, M	Approximate Intervel Between
	imn	nediate Ceuse (	Finel	nly one cause or	weg a s									Onset and Death
al Examiner	res	ulting in death)		e/1	Duelo	or as a consec	uence of):						1	
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by Physician/M	Part	II. Other signifi	icant condition	s contributing to	death but not re	sulting in the u	nderlying ceu	se giv	en in Part			tobacco uae c Yee 2□ No		o the cause of death? bably 4 Unknown
Completed b										e	24a. Was	s an autopsy ormed?	av	ere autopsy findings vallable prior to empletion of cause death?
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Certific		3 Suicide 4 ☐ Homicide	6 Could no determin	Ari 200. Pie	ce of Injury - At I ding, etc. (Spec	nome, ferm, str ify)	eet, factory, o	le	ce		28f. Location ( City or To	(Street end Nur wn, Stete) 6		el Route Number, Ywk Auf
dicai	29a	Certifier (Check only one)		Physician: To the caminer: On the and ma										
completely filled in by the Medical Certifical		. Signature and	fitte of certifler	181 8.4	11		29c. L	icens	se number			29d. Date sign	ned (Month,	Dey, Year)
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Registrar

MAR 3 0 2000

State of Maryland / Department of Health and Mental Hygiene 00 11963

			C	ertifica	ate of	Death		Reg. No.		
Physician	1. Decedent's Nama (First, Middle, L						2. Data of De Month	Day	Year 3. Time o	
/Medical	NORMA C. HOCK						March			P.M.
Examiner	4a Facility Nama (If not institution, g						r Location of Deatl			
	Anne Arundel Med			al If I had	der 1 Year	Annapol:			Arundel	
Funeral Director	151-18-1122	Sex 1 M 2 F 7. Age (In y	rs. last birthda Yrs.	Month		Hours Min		, 1927	9. Birthplace (State Country) New Jersey	or Foreig
Bu .	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location					10d. Inside C	
oto oto	Maryland Anne Ar	undel		Edgew	ater				1 □ Yes	2 N
here 23e or 25e-f show ther must be notified at uneral Director	10e. Street and Number 1212 Bayview Cour	·t		10f. 2	Zip Code 210	037		10g. Citizen of V		
Exami	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 24 Yeo If Yes, Give Year or Dates:	U,S. 1:			Hispanic Origin? ( ean, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rac Blac Specify	e - American Indian, ck, White, etc.	
t, the Medical Completed	15. Decedent's (Specify only highest g	reda complated)  College (1-4or 5+)				pation during most of we d)	orking		usiness/Industry	
Cor the		2 yrs.	R	egist	ered	Nurse		Medi		
To Be	17. Fathar's Nama (First, Middla, Las George B.	mcClellan Cla	yton				ame (First, Middle ileen Ma		10)	
a l	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	alling Addre	ess (Street	end Number or F	Rural Route Numb	er, City or Town,	State, Zip Code)	
4	Gail G. Czarnecki	/ Daughter	121	2 Bay	view	Ct. Ed	gewater,	MD 2103	37	
nt: If lien ny or oth	20a. Method of Disposition  1 Burial 200 Cremation 3  4 Donation 5 Other (Spec	Removal from State	Place of Dis cemetery, c etropo	remetory o	r other ple		3-28-00		City or Town, State	
any inju	21. Signature of Edneral Segreta Mo	forson,		22. Name Georg	e P.	Kalas Fi	uneral Ho	ome Edgewate	er, MD 2103	27
sician edical miner	23a. Part 1. Enter the disease, or conshock, or heart failura. List only immediate Cause (Final disease or condition resulting in death)	a. Electrome		l di	SSOC				Onset and	Death
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s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	0.	(or as a cons	sequence o						
he bu	Cause (Disease or Injury that initiated events resulting in death) Last	VI.	(or as a cons		-					
-		d. Status post	peraud	aneou	> an	qioplusy			5 ho	urs
d for	Part II. Other significant conditions	contributing to death but not	reculting in the	undorkini	n cauca ni	ven in Part I	23h Did	tobacco use co	ntribute to the cause	of death
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age 2							10	Yes 28 No	1 ☐ Yas 2 ☐	∃ No.
o. p	25. Was case referred to medical					26 Place of D	eath (Check only		12.00	
il director	axaminer? 1 ☑ Yas 2 ☑ No	Hospitel:	☐ ER/Outpat	ient 3	DOA Ot	her	Home 5 ☐ Resi		ner (Specify)	
funeral funeral	27. Manner of Death  1	28a. Date of Injury (Month, Dey Year		of	28c. Inju			how injury occur		
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Comp	3 Suicide 6 Could not determine	be one Class of laive. A	t home, farm,	street, fact	ory, office		28f. Location ( City or To		ber or Rurel Route Nu	mber,
Medical C	29a, Cartifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my laminer: On the basis of exam and manner stated.	nowledge, de ination and/or	ath occurre Investigati	ed at the ti	ime, date and plac opinion, deeth occ	ce, and due to the curred at the time,	cause(s) and madate end place,	annar as stated. and due to the cause	(s)
Me off	29b. Signature and tible of certifier	0		1	29c. Lican	sa numbar		29d. Date signe	d (Month, Dey, Year)	
. 0	1 John	orthon			D45	019		MARCH 2	8,2000	
	30. Neme and sources of person who	completed cause of death (I	tem 23a) (Typ 04 For	pe, Print) わどら	SHS	Suite 200	ANNA	pous M	0	
State	31. Data filed (Month, Dey, Year)	32. Registrar's Sig	nature	1. 14	pou	(2)				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ENUAND. HOLSTEN /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE 8. Date of Birth (Month, Dey, Year) Oct. 23, 1904 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) **Funeral** Months Hours 95 143-10-4214 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Arundel Beach Road 21146 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ XNo
If Yes, Give
Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Garage Foreman Local Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17, Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Charles H. Holsten Minnie Binde 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Heller / daughter 1211 Hillcrest Rd. Arnold, MD 21012 ortant: If Item 27 Injury or other to 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3-28-00 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, MD. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Physician 1 HOUR /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 36WITES 4000 of Vital Records. ģ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3000A 20110 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes this 27. Manner of Death 1 (INstural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation or Attanding To the Hospital or Attandit within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 D Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as stated. completely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

MAR 2 8 2000 DHMH 16 Rev 6/95

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ome

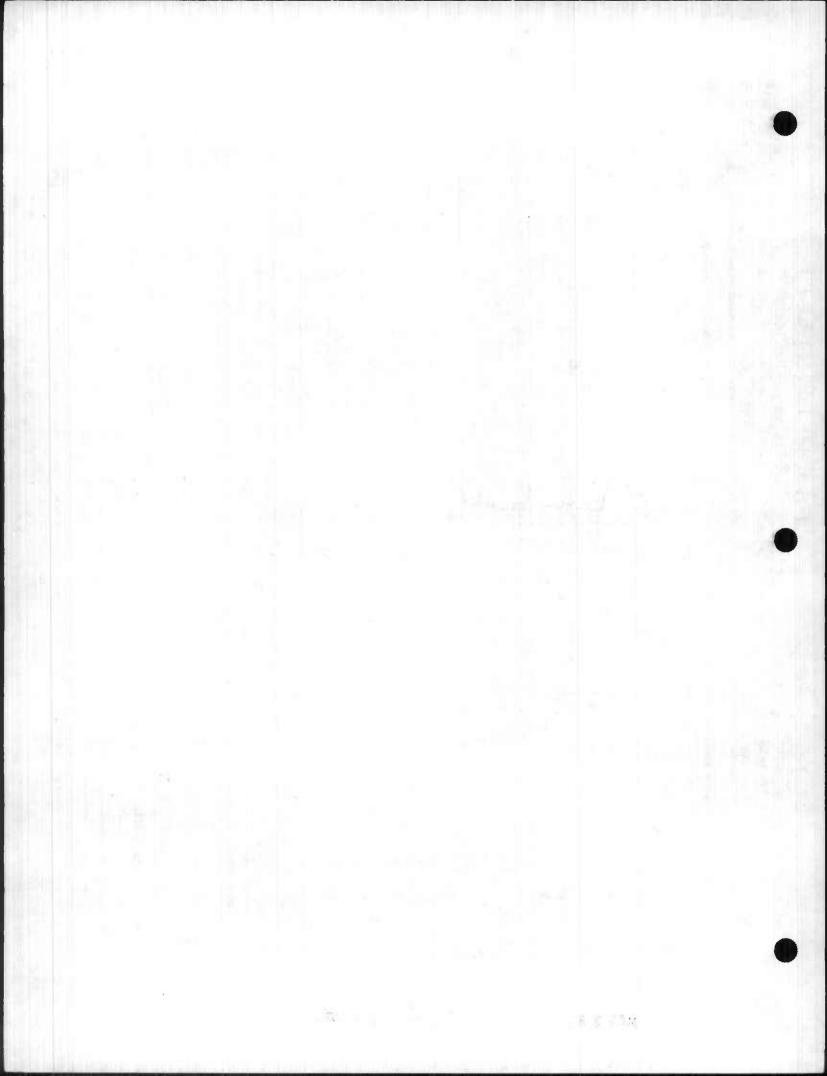
32. Registrar's Signeture

16/6

29c. License number

In it Manspolis

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name								2. Date of De		Vana	3. Time of Dea
Physician /Medical	Cat	herine (	Gertrude	Jones					Month 03	Day 28	2000	1:10 PM
Examiner	4a Facility Name (II	not institution, gi	ive street and nun	nber)			4b. City,	Town, or Le	ocation of Deat		nty of Death	1
	Knollwood	Manor C	Genesis H	Elderca	ire		Mil	lersv	ille	Anne	e Arur	ndel
uneral irector	5. Social Security No. 577 24 87	01		7. Age (In yrs. 36	lest birthday) Yrs.	If Under 1 Months E		der 24 Hrs. rs Min.	8. Date of Bir 04/05/	4913	9. Birth Cou Was	nplace (State or Fo unitry) shington
	Usual Residence of 10a. State	Decedent 10b. County		100 Ci	ty. Town or Lo	nonting						404 beside Obert
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5 4 6	10e. Street and Num 1734 Rem		Orive			10f. Zip Co	ode 11114			10g. Citizen o	of What Cou	untry?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death MARCH 30, 2000 **Physician** LUCILE MARZELLA KENLEY 1:20 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WALDORF CHARLES. 306 TOMPKINS LANE If Under 24 Hrs. If Under 1 Yeer Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□ M 2以F 75 Director 386-20-3015 OCTOBER 15, 1924 MICHIGAN Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or flams 23s or 28s-f show must be notified at 1 Yes 2 No Directo CHARLES BRANDYWINE MARYLAND 10e. Street and Number 10f. Zio Code 10g Citizen of What Country? 20613 16020 BEECH NUT DRIVE U.S.A. Funera Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 朝 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE À 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. AIRFORCE Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER OF MILITARY BASE EXCHANGE 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be 2 Department of Health and Merital Important: If Item 27 is marked or any Injury or other traumatic eve once. LULU GALLOWAY ERNIE L. DINGMAN Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 16020 BEECH NUT DRIVE, BRANDYWINE, MARYLAND 20613 JUDY ANN BALL/DAUGHTER 20b. Plece of Disposition (Nema of cametary, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removel from State PETER'S CHURCH CEMETERY 4/4/2000 WALDORF, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral Revole License 22. Neme end Address of Fecility
THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX JPK 156, WALDORF, MARYLAND 20604-0156 JOHN P. KNISLEY M01164 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or haert failura. List only one cause on each lina. Approximete Intarvel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 72 hours Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a conseque Box 68760 Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by 1 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed has 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificate 25. Wes case referred to medical axeminer? Be 26. Place of Deeth (Check only one) Daughters 1 Yes 2 No Hospitat: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify, edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this home 28d. Describe how injury occurred 27. Mennar of Death 28b. Tima of 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? After Neturel 2 Accident or Attending 5 Pending n 24 hours after death. The Funeral Director: Alt pletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier (Check only one) To the P within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier ow March 31, 2000 MO D21607 30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print) 10905 Fest Washington Rd #405 Ft Washington MD 20744 Gage;

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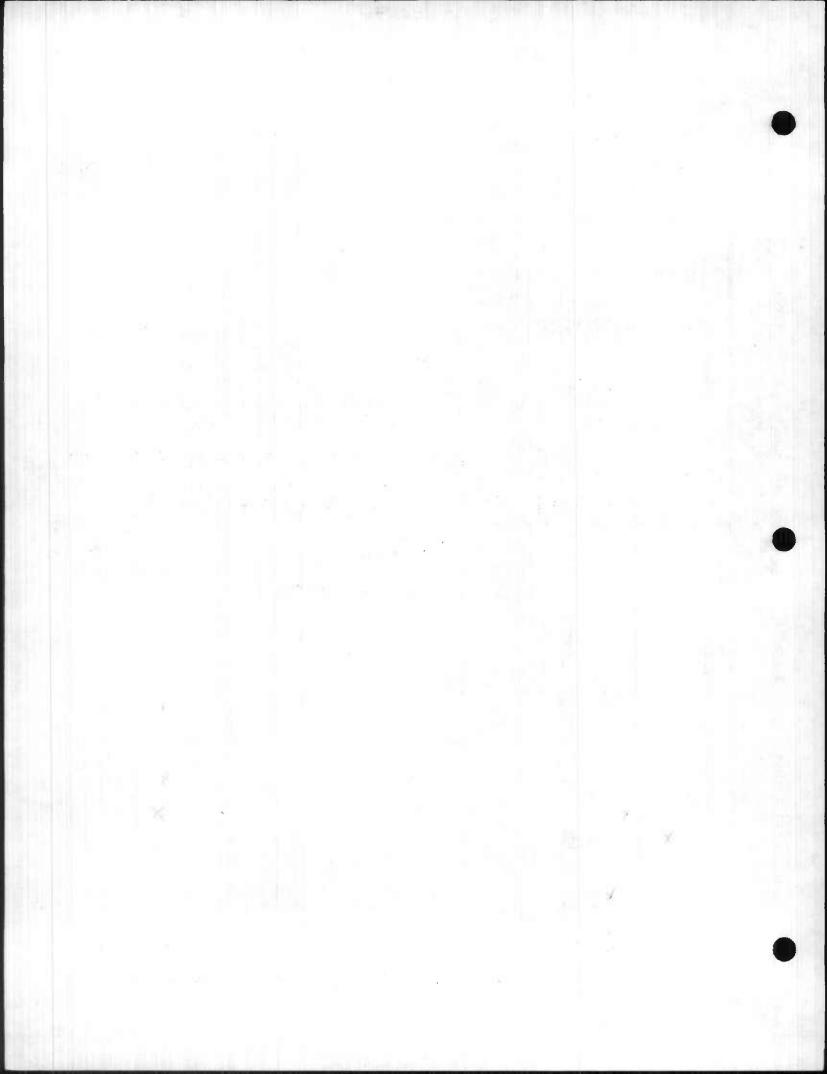
Registrar

31. Dete filed (Month, Dav. Year)

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32. Registrar's Signature

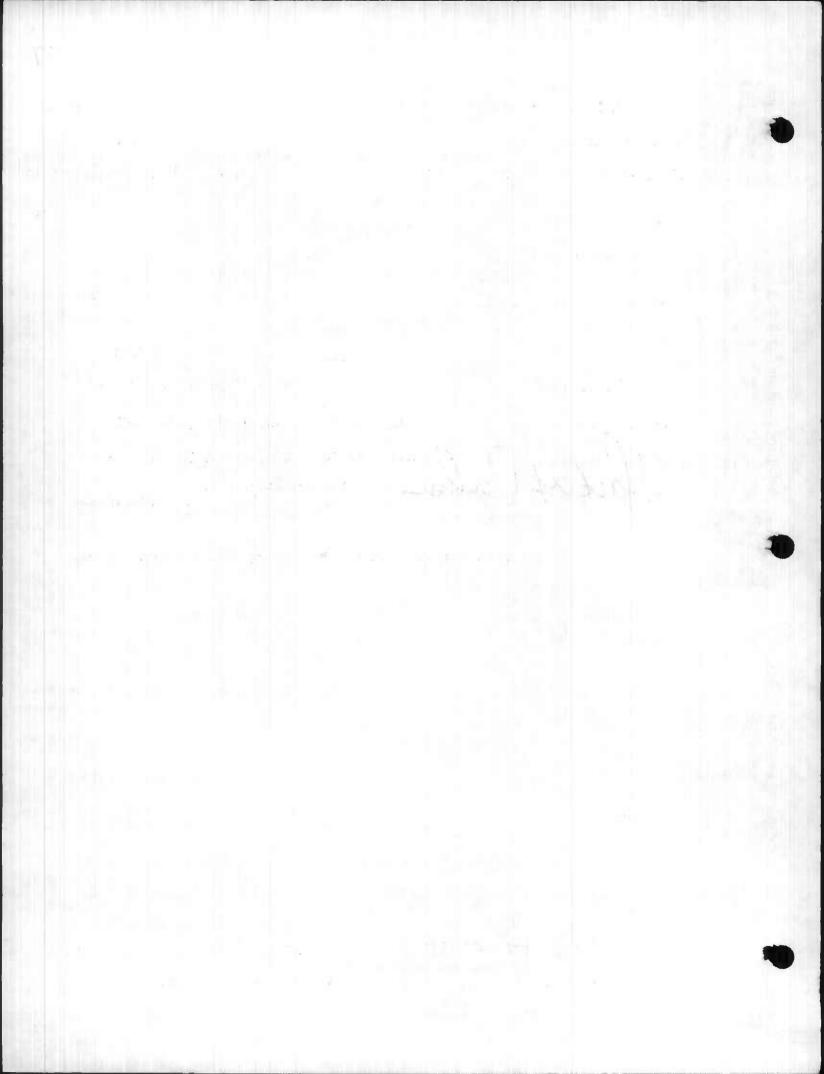
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State of Maryland / Department of Health and Mental Hygiene

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 0/05 Day 1, 2080 aru 11:12A arch 4b. City, Town, or Location of Death 4a Facility Nama (Il not Institution, give street and number) 4c. County of Death Itimore Sonns HOPKINS 105 ta If Under If Under 24 Hrs Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) Months 1□M 2√F 66 070-26-6257 Sept. 9, 1933 New York Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits NY 1 Yas 2 No Broome Endwell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3620 Beatrice Lane 13760 IISA 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Giva 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) Owner/Operator Hair Styling/Retail 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Donald Cowan Elizabeth Alverson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3620 Beatrice Lane Harry Koloski/Husband Endwell, NY 13760 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Mar 25 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 2000 Endicott, NY Twin Tiers Cremation 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 Berrance, 41 ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. tmmediate Causa (Final disaasa or condition rasulting in death) consequence of): 0 Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas No 1 X Yas 2 No 25. Was case refarred to medical examinar? 26. Place of Death (Check only ona) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas No

Examiner that the death certificate be executed physician and the burial-transit Box 68760 Physician/Medical 980 P.O. signed by t Records. Completed page 2 has certificate Division of Vital or Attending Physician: Certification: To this Atter To the Hospital or Attending within 24 hours attardeath. To the Funeral Director: Afte completely filled in by the fun

by

Be

edical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ahow

288-1

the Medical Examiner must be notified at

filed within 72 hours eftar death with Hygiene.
Wher than "natural", or items 23s or

i. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 Is marked other th ijury or other traumatic avant, the

permit. Page Department of Important: If any Injury or page.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

by

Completed

Be

the Maryland

28d. Describe how injury occurred Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No invastigation 2 Accident

6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier les-

30. Nama and eddrass of person who completed cause of death (Item 23a) (Type, Print) North Wolfe Street, Beltimore, MD 2128-Le ter 1. Chal

State Registrar 31. Data filed (Month, Day, Year) MAR 2 4 2000 32. Figgistrar's Signature

MAK 2 & 2 MIT S & S HAM

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1969 Certificate of Death

Physician
/Medical
Examiner

P.M.

rida

Rockville, MD

**Funeral** 

Director

**Physician** /Medical

Baltimore, Maryland 21215-0020

Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Nospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

JOSEPH A. KLIOZ								2. Dete of De			3. Time of Death
	ZE							Month March	28, 200	) O Year	10:50 P.M
4a Facility Name (If not institution, giv	re street and no	umber)			4	b. City, To	own, or L	ocation of Deat	h 4c. County	y of Death	1
Hebrew Home of	Greate	r Washi	ington			Rock	vill	.e	Mont	gome	ry
5. Social Security Number 6. 5	Sex	7. Age (In yr.	s. last birthday	If Under 1 Y		If Under		8. Date of Bir (Month, Da	rth	9. Birth	nplaca (State or Foreign
370 31 2227	M 2DF	93		Months D	ays	Hours	Min.	August	4, 1906	Cou	uryland
Usual Residence of Decedent  10a. Stata  10b. County		100.0	City, Town or L	onation							10d Incide City Limits
Maryland Montgo	omery		Rockvil								10d. Inside City Limits  Yes 2□ No
10e. Street and Number				10f. Zip Co	ode				10g. Citizen of	What Co	untry?
1214 Treasure Oa	ak Cour	t		2	208	52			U.S.	Α.	
11, Marital Status  1 Nevar Married 2 Married 3 M Widowed 4 Divorced	12. Was Dec Armed F 1  Yes If Yes, G Year or I		U,S. 13.	. Was Decedent If Yes, specify 1 ☐ Yes 💥	Cuba	ispanic Or in, Mexica Specify:	n, Puarto	ecify Yes or No Rican, etc.)		ck, White	rican Indian, n, etc. nite
15. Decedent's Education (Specify only highest gra	ducation	)	16a. Dec	edent's Usual O	ocupa	ation	st of work	ina	16b. Kind of B	lusiness/l	ndustry
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12 5 m + 1 m + 15 m + 1 m + 1		aı	De	licates	sei				Giant		
17. Father's Name (First, Middle, Last, Solomon Klioze	,								, Maiden Sumar		
SOTOMON KITUZE						Ida	(01	ascerta	ainable)		
19a. Informent's Name/Relationship (	Type, Print)		19b. Mei	ling Address (S	treet a	and Numb	er or Rur	al Route Numb	er, City or Town	, State, Z	(ip Code)
Verna S. Lazerr	nik - D	aughter	1214	Treasu	ire	0ak	Cour	t, Rocl	kville,	Mary	land 20852
20a. Method of Disposition  1		State	cametery, cre	position (Name of ematory or other David M	r plac		dens	2/2000	N. Laud		Town, State
			ے ا	22 Name and A	Addras	s of Facili	itv	26	1 01	ч	-
21. Signature of Funeral Service Licer											200
21. Signature of Funeral Service Licer	ne.			anzansk							
23a. Part1. Enter the disease, or com shock, or heert failure. List only	Stot	caused the sime	us 1	170 Roc	kv:	ille	Pike	, Rock	ville, M		Approximate Interval Between
Monald C.	Stot	ST	us 1	170 Roc	kv:	ille	Pike	, Rock	ville, M		and 20852
23a. Part1. Enter the disease, or com shock, or heert failure. List only  Immediate Cause (Final disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate	Stot	ST Due to	ath. Do not er	170 Roconter tha mode of	kv:	ille	Pike	, Rock	ville, M		Approximate Interval Between
23a. Part1. Enter the disease, or com shock, or heert failure. List only  Immediate Cause (Final disease or condition resulting in death)  Sequentielly list conditions.	Stot	ST Due to	ath. Do not en	170 Roc onter the mode of sequence of):	kv:	ille	Pike	, Rock	ville, M		Approximate Interval Between
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23a. Part1. Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last	Diotal plications that one ceuse on a b d	Due to  Due to  Due to	ath. Do not en	170 Roc onter the mode of the requested	kv:	ille g. such as	Pike cardiac	23b. Did	ville, M	faryl aryl antribute 3 pr	and 20852  Approximate Interval Between Onset and Death  to the cause of death?  obably 4 Unknown  Were autopsy findings available prior to completion of cause
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23a. Part1. Enter the disease, or comshock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last  Part II. Other algnificant conditions of the conditions of th	b	Due to  Due to  Due to  Due to  Art	ath. Do not en	170 Roc onter the mode of CE sequence of): squence of): underlying caus  UNCLUDE STATE OF THE ST	kv: d dying	ille g, such as an in Part  26. Place	Pike cardiac	23b. Did 1	tobacco uae co Yes 2 No s an autopsy ormed?  Yes 2 No one)	faryl antribute 3 Pr	Approximate Interval Between Onset and Death O
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**DHMH 16 Rev 6/95** 

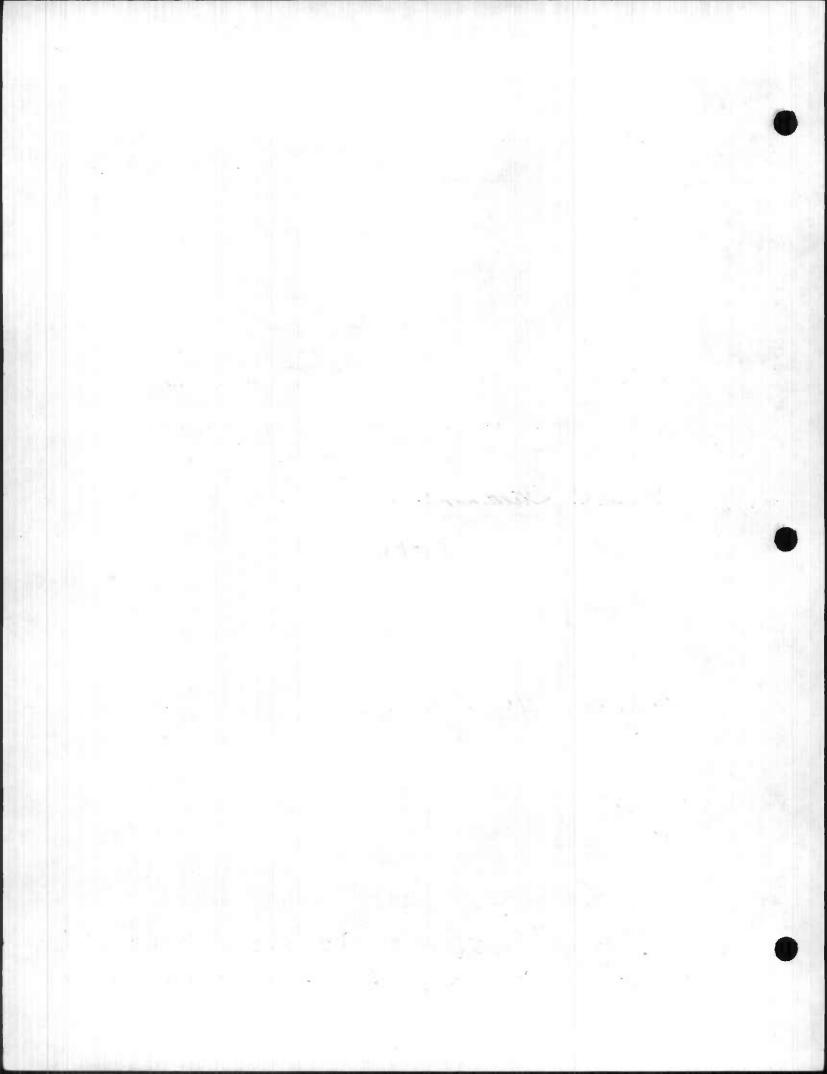
State

Registrar

31. Date filed (Month, Day, Year)

MAR 31

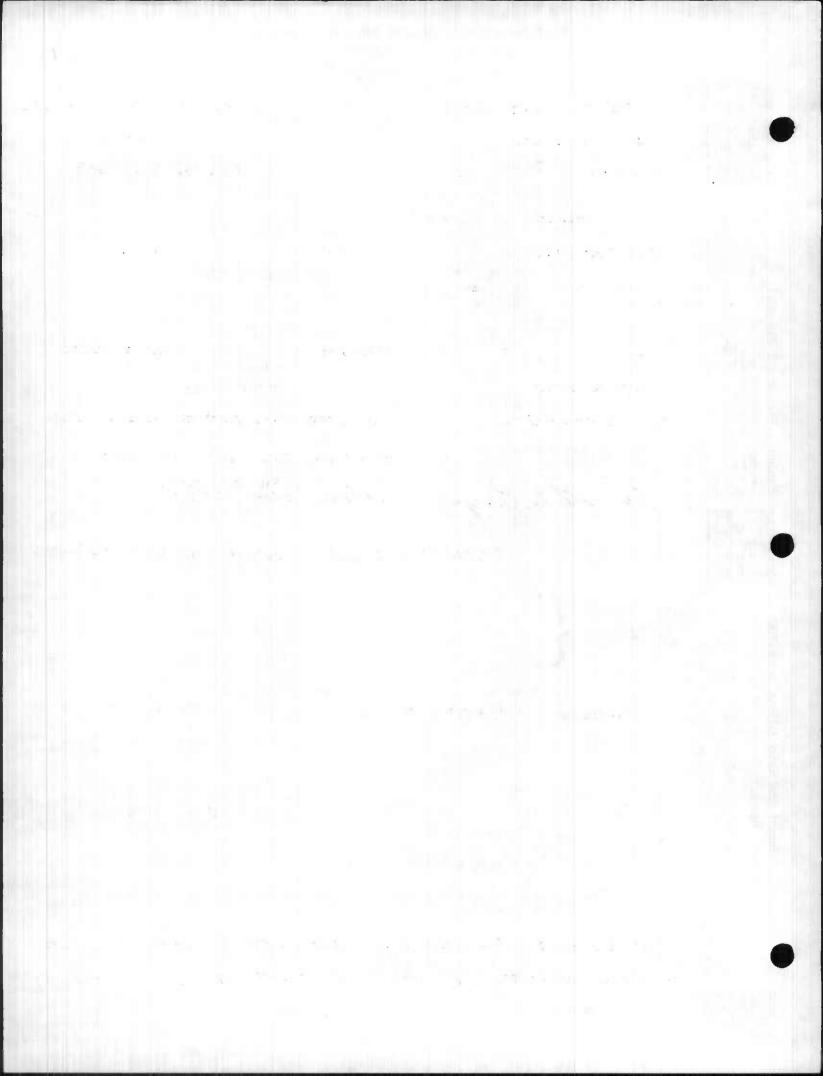
2000



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 00 11970

					C	ertificat	e of	Death			Reg. No.			
		1. Decedent's Neme (First, Mid	de, Last)	HC.						2. Dete of De Month	eth Dey	Yeer	3. Time of Death	
	Physician /Medical	Tadeusz	Henry	Lese	er					March			9:45 A.M.	
	Examiner	4e Facility Neme (If not instituti	on, give street end	d number)				4b. City, To	wn, or Lo	ocation of Deeth	4c. County	of Death		
44		1205 Medwo	od Court					Bel A	Air		Hai	rford		
	Funeral	5. Sociel Security Number	6. Sex 1 → M 2 □	7. Age (i	In yrs. lest birthde	/) If Unde		If Under Hours	24 Hrs. Min.	8. Dete of Bir	th	9. Birthp	lece (Stete or Foreign	
-	Director	405-42-3663	1E3M 2L	9	11 Yrs.					Dec. 1	4, 1908	Pola	ind	
	D & 2	Usual Residence of Decedent  10e. Stete 10b. Count	v	11	Oc. City, Town or	ocation						1	0d. Inside City Limits	
	Varyla f shov		ford		Bel Ai								1 ☐ Yes 2\\\O\\\O\\O\	
	Pecto Pecto	10e. Street and Number	TOLU		DCI AII	10f. Zig	Codo				10g. Citizen of	Affhat Cours		
	witer death with the Marking tems 23a or 28a-fs and 23a or 28a-fs and the mortiled Funeral Director	1205 Midwood	Ct.				2101	4			U.S.		uyr	
	iner dea	11. Maritel Status	12. Wes I	Decedent Eve d Forces?	er in U,S. 13	. Wes Dece	dent of i	Hispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 14. Red Bie	e - Americ		
21215-0020	er, o	1 Never Merried 2 Ma 3 Widowed 4 Divorce	. If Yes	es 2 XNo , Give or Detes:		1 ☐ Yes					Specif			
2-0	be filed within 72 ho tel Hygiene. d other than "nature event, the Medical Be Completed	15. Decede (Specify only high	nt's Education	ted)	(Gir	edent's Usu e kind of wo	ork done	during mos	t of work	Ing	16b. Kind ot B	usiness/Inc	Justry	
121	mpi mpi	Elementery/Secondary (0-12)	Coile	ge (1-4or 5+)		DO NOT u					II C C	`0110×**	mont	
CA	Hygie Hygie ont, to o Co	12	(toot)	3		Mathem	atio	_	ore Nam	o /First Middle	U.S. G		meric	
and	Be very	17. Fether's Neme (First, Middle									, <i>Maiden Sum</i> en	110)		
Z	should ind Men and Men	Zugmunt I	eser		101-14-	Maria Andria	- /01		Amil		erma er, City or Town,	Ctata Zin	Code	
Z	abemit. Peges 1 and 2 should Department of Heelth and Mer mportant: If feen 27 is market any Injury or other traumatic ance. To	Henry Wisniews				-					en, Mary		21001	
ore	of He	20e. Method of Disposition 1 □ Burlel 2 □ Cremetlor	3 □Removel fr		20b. Piece of Dis cemetery, co	ematory or o	other pla			Dete	20c. Location			
E	Peges ment of I ant: If its ury or or	4 Donetion 5 Other		om otoro	R. A. F	erris	& C	o., Ir	nc.	3/30/00	West Ch	neste	r, PA	
Baltimore,	permit. Peges 1 and Department of Heelth Important: If item 27 eny injury or other the page.	21. Signeture of Fune of Service	Licansee	0		Tarri	nd Addre	cargo Mary	Fune	eral Ho	me,P.A. 1-3399			
		23a. Part1. Enter the disease,	or complications the	net caused the	e death. Do not e								Approximate	
	Physician	shock, or heart feilure. Li	at only one ceuse	on each line.								1	Onset end Deeth	
	/Medical	Immediate Ceuse (Finei		+100	1617			, ,	10		ARIN	VOIM	3 VENAS	
	Examiner	disease or condition resulting in deeth)	θ					L C.	ARC	INOW	שורים	HEN.	3 YEARS	
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	executed In end Ital-transit		b	Du	e to (or es e cons	oguence et)						1		
ć	requires that the deeth certificate be executed seen signed by the attending physician end should be detached for use as the bunal-transit eted by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Du	e to (or es e cons	equence or)						i		
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68	beeth certificate be attending physicie of or use as the bu clan/Medical	resulting in deeth) Lest			0 10 10. 00 0 00	.,.								
Вох	use use		d											
0	thet the deeth cer ed by the attendin detached for use / Physician/N	Pert II. Other eignificant condit	lone contributing	to death but r	not resulting In the	underlying	cause gi	ven in Pert I	l	23b. Dld	tobacco uee co	ntribute to	the cause of death?	
P.0	by the	/SCHEV			- DISE					10	Yee 25000	3⊡ Prol	bably 4 Unknown	
S, F	signed I d be det	1001181	1116 /	10-MM	DIO	1 20								
Record	been si should l										en autopsy ormed?	evi	ere eutopsy tindings eilable prior to	
20	\$ 50 G											of	mpletion of cause death?	
æ	The law sete has the page 2 s									1 🗆	Yes 2 No	10	Yes 2□ No	
	certificate rector, pag	25. Wes case referred to medic	al					26. Place	e of Deet	h (Check only	one)			
>	Physician: this certific and director, TO Be (	exeminer?	Hospitel:	I ☐ Inpatient	2 ER/Outpat	ent 3 D	OA Ot	her: 4 Nu	ursing Ho	ome 5 Resi	denca 6 □Otf	ner (Specif	y)	
of	4 4 4	27. Menner ot Deeth	28a. D	ete of Injury Month, Dey Y	28b. Time	ot :	28c. Inju				how injury occur			
io	Attending is a death.  • ctor: After by the funer iffication:	1 Neturel 5 Pend 2 Accident inves	tigation	violiti, boy i	out/ wijury	М		Yes 2	No					
Division	Arte er de er de by th	3 Sulcide 6 Could 4 Homicide deter	mined 208. P	lece of Injury uilding, etc. (	- At home, ferm,	street, fector	y, office			28f. Location (	Street and Numi	ber or Rura	Il Route Number,	
0	tal or Attending P rs after death. al Director: After t ed in by the funer: Certification:	- Tromole		anorig, etc. (	Specify)					ony or vo	, , , , , ,			
	To the Hospital or Attend within 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29e. Certifier 1 Certify (Check only one)	ng Phyeician: To I Examiner: On the	the best of me basis of ex	eminetion end/or	ath occurred investigetion	et the ti	ime, date en opinion, dee	nd place, oth occur	end due to the red et the time,	ceuse(s) end m dete and piace,	enner es si end due to	tated. the cause(s)	
	vithin on the	29b. Signeture end title of cartit		4		29	c. Licen	se number			29d. Dete signe	ed (Month,	Dey, Year)	
		Andrew	Now	kow.	le N	B	D	080	90		MARCH	29	2000	
	20	30. Neme and address of person AND REW	who completed	cause ot deet	h (item 23e) (Typ	e, Print)	), —	11 1	2210	/ 5-	0 200 4	p 4.	2021-14	
	State	31. Dete tiled (Month, Day, Yea	2007K	2. Registrar's	Signeture	1-	40	10, 10	THE STATE OF THE S	۵/,	6621711	n, m	DAIOIT	
	Registrar	MAI	3 U ZUUL	1		/J.	120	acke	1					



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Certificate of Death Reg. No.		11011
state of Maryland / Department of Health and Mental Hygiene	00	11971
	-	

10d. Inside City Limits

10g. Citizen of What Country?

14. Raca - American Indien Black, White, etc.

Specify:WHITE

16b. Kind of Business/Industry

HOME

18. Mother's Name (First, Middle, Maiden Sumeme)

MILSTEAD

DUNKIRK,MD. 20754

UNITED STATES

1 ☐ Yes 2 No

Physician /Medical **Examiner** 

1. Decedent'e Neme (First, Middle, Last) 2. Dete of Death Month MARCH 2 3. Time of Death 27, 2000 1PM MAYO ELIZABETH LUDDEN 4a Facility Neme (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL 140 PATUXENT MOBILE ESTATES LOTHIAN If Under 1 Year | If Under 24 Hrs 8. Dete of Birth (Month, Day, JUNE 02 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) MARYLAND 1 M 2 F Months Days Hours

10f. Zip Code

HOMEMAKER

20711

1 Yes 2XNo Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

ELIZABETH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

81

LOTHIAN

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:

College (1-4or 5+)

10c. City, Town or Location

Funeral Director

579 07 4275

10a, State

MARYLAND

10e. Street and Number

Directo

Completed by Funeral

Be

Usual Residence of Decedent

1 Never Married 2 Merried

3 Widowed 4 □ Divorced

Elementery/Secondery (0-12)

17. Father's Neme (First, Middle, Last)

MAURY I. DEAKINS

19a. Informant's Neme/Reletionship (Type, Print)

PETER WISNIEWSKI M.D.

MAR 2 9 2000

31. Date filed (Month, Day, Year)

10b. County

ANNE ARUNDEL

140 PATUXENT MOBILE ESTATES

15. Decedent's Education (Specify only highest grede completed)

28a-f show

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

ant. If fern 27 is marked other than "netural", or he

Baitimore, Maryland 21215-0020

**Physician** /Medical Examiner

The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should t To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760,

JACOUELYNNE MULDE	CR (NIECE)	40 PATU	KENT MOBILE	ESTATES LOTHIAN,	MD. 20711
20e. Method of Disposition	20b. Plece	of Disposition (Ne	me of		City or Town, Stete
1 ☐ Buriel 2XX Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	removel from Stete			03-29-00 ALEXAND	DRIA, VA.
21. Signeture of Funeral Service Coers	1/25			EORGE P. KALAS F AND ROAD EDGEWAT	
23a. Pert1. Enter the disease, or compl shock, or heert feilure. List only o	licetions thet caused the death. Do ne ceuse on each line.	not enter the mod	de of dying, such es cardie	ac or respiratory errest,	Approximete Intervel Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	COLON C	ANLE	R		3 YEARS
Toodking in obality	Due to (or as e	consequence of)			1
	b	consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Due to (or es a	consequence or).			1985 - 166
thet initiated events resulting in death) Last	Due to (or as e	consequence of):			
Pert II. Other eignificant conditions con	ntributing to death but not resulting	in the underlying o	cause given in Pert I.	23b. Did tobacco use cor	ntribute to the cause of death
CHRONIC OBS	TRUCTIVE L	UNG 7	DISEASE	1 Yee 2□ No	3 Probably 4 Unknow
				24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause
				1□ Yes 2 No	of death? 1 ☐ Yes 2 ☐ No
25. Wes case referred to medical exeminer?			28. Place of De	eeth (Check only one)	
1 Yes 2 No	lospitel: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 Do	OA Other: 4 Nursing	Home 5 Residence 6 □Othe	er (Specify)
27. Menner of Death  1 Naturel 5 Pending 2 Accident investigation		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurr	ed
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At home, for building, etc. (Specify)	28f. Location (Street end Numb. City or Town, Stete)	er or Rural Route Number,		
				and due to the councie) and ma	
29e. Certifier (Check only one) Certifying Physical Examination (Check only one)	aiclan: To the best of my knowledger: On the basis of examination are and manner stated.	e, deeth occurred nd/or investigation	et the time, date end place, in my opinion, death occ	eurred at the time, date and pleca, a	nner es steted. and due to the cause(s)
(Check only 2 Medical Exami	ner: On the basis of examination ar	nd/or investigation	et the time, date and place, in my opinion, death occ.  License number	curred at the time, date and pleca, a	and due to the cause(s)  If (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State Registrar

10845 TOWN CENTER BOULEVARD

32. Registrer's Signeture

oner of state

## Piease Type or Print in Black indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  $U\,U$ Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Evelyn B. McNeal MARCH 29 10:11 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6 Sax 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1□M 25F 213-05-6159 Director July 6, 1909 Maryland Usual Rasidence of Decedant 10c City Town or Location 10a Stata 10h County 10d. Inside City Limits tem 27 is marked other than "natural", or fama 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 X Yas 2 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Pennsylvania Avenue 21921 Funeral United States
14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry al Hyglene. Elementery/Secondery (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked of eny Injury or other traumatic eve Montgomery Thomas Boyd Nettie Street 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ronald V. McNeal/Son P.O. Box 237, 1686 Ridge Road, Corolla, NC 27927 ce of Disposition (Name of Date 20c. Location City or Town, Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 4/3/00 West Chester, PA 21. Signatura of Funeral Servica Licansee 22. Name and Address of Facility Hicks Home for Funerals 103 W. Stockton St., Elkton, MD 21921 anal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner physician and s the burial-transit Sequentially list conditions, if any, laeding to immadiata cause. Entar Undarlying Cause (Disaese or Injury that initiated avants rasulting in death) Last Box 68760. edicai Quewk Physician/M Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wera autopsy findings available prior to 24a. Was en eutopsy performed? Completed peed completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes casa ratarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yas 2⊡No 2 1 Department 2 ER/Outpetient 3 DOA this 28a. Data of Injury (Month, Day Year) he Hospital or Attending Pin 24 hours after death.

he Funeral Director: After the pletchy filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Netural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifian 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the tima, date and place, and due to the cause(s) and menner stated. To the To To the F 29c. License number 29d. Date signed (Month, Day, Year) 30. Marria and address of person who completed cause of death (Item 23a) (Type, Print) Sid-K-Bateli, MY B 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

**DHMH 16 Rev 6/95** 

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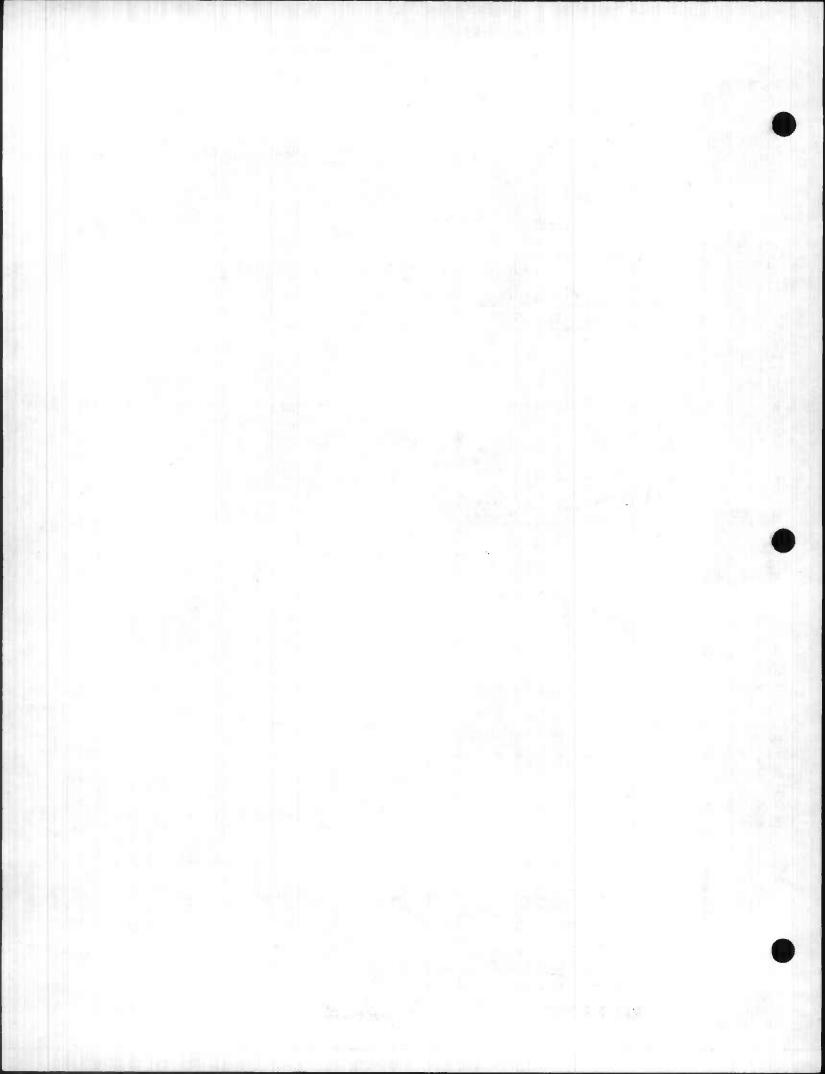
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Morales Day Month **Physician** John March 26, 2000 7:10 a.m. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 686 Fairview Ave. If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiace (State or Foraign Country) **Funeral** Months Days 1 GM 2□ F 79 579-18-2820 Director December 1,1920 Washington, DC Usual Rasidence of Decedant 10b. County 10c. City Town or Location d 2 should be filed within 72 hours efter death with the Manylan Ih and Mental Ihygiene.
7 is marked other than "natural", or flema 23s or 28sef show traumatic svent, the Medical Estimate must be notified at 10a. Stata 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 United States 686 Fairview Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forcas? \(\mathbb{T}\) Yas 2 \(\mathbb{N}\) No 17 As, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 19 46a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Distributor Owner/Operator 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be f nent of Heelth and Mental I mt: If Item 27 is marked of Gladys Kent Leon E. Morales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Syble A. Morales (Wife) MD. 21403 686 Fairview Ave. Annapolis, t: If Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removel from State 4 Donetion 5 Other (Specify) Jepartment 3-29-00 Ft, Lincoln Crematory Brentwood, Maryland of Fundul Sarvice Licensee 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of MOOTES 23a. Part1. Entar tha disaasa, or complications transcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical C0/00 2 years **Examiner** Physician/Medical Examiner The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): USe P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 1150916 Records, Ď 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy performed? Completed 1 Yas 20 No 1 □ Yas 2 No of Vital Physicien: 25. Was casa raferred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Division or Attending 5 Panding invastigation 2 Accident deeth. 1 Yes 2 No after deeth 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours af To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely (Check only one) 29b. Signatura ang 29c. License number 29d. Data signed (Month, Day, Year) Matthew Malta 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 21401 11.00 32. Registrar's Signature 31. Data filed (Month, Day, Year) State MAR 2 8 2000 Registrar



### Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11974 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death PERFELS Month Day 10.448 LAWRENCE.O. 03 29 00 4a Facility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 25, 1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Michigan 574107866 Usual Residence of Decedent 60 10d. Inside City Limits 10c. City, Town or Location Maryland 1 ☑ Yes 2 ☐ No Cecil Perryville 10e. Sfreet and Number 10g. Citizen of What Country? 10f. Zip Code 636 Honicker Street 21903 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Status 1 Never Merried 20 Married 1 M Yas 2 □ No If Yes, Give Year or Dates:1958-64 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aberdeen Proving Ground Elementery/Secondary (0-12) Twelve Years College (1-4or 5+) Communications Specialist Aberdeen, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Henry Peffers Vera Ethel Huntley 19a. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Janet Lee Jackson Peffers (wife) 636 Honicker Street, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cramation 3 □ Removel from State Asbury Cemetery 4/3/00 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each tine. Approximete Intervel Between Onset and Death METATESIS CANCER LUNG Due to (or es a consequence of): CANCEL LUNG Immediate Cause (Finel disease or condition resulting in death) Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last LUNS E SECONDAMES 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown

Physician/Medical Examiner after deat Director: within 24 hours after de To the Funeral Directo completely filled in by ti

**Physician** 

/Medical

Examiner

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Director

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					performed?	available prior to completion of cause of death?  1 Yes 2 No
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examiner?		Hospitel: 1 ☐ Inpatient 2	ER/Outpatient 3□ DO	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
2 Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pieca of Injury - At h building, etc. (Speci	ome, farm, street, factor	y, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,

29b. Signatura and title of certifiar 29d. Date signed (Month, Day, Year) 29c. Licensa number

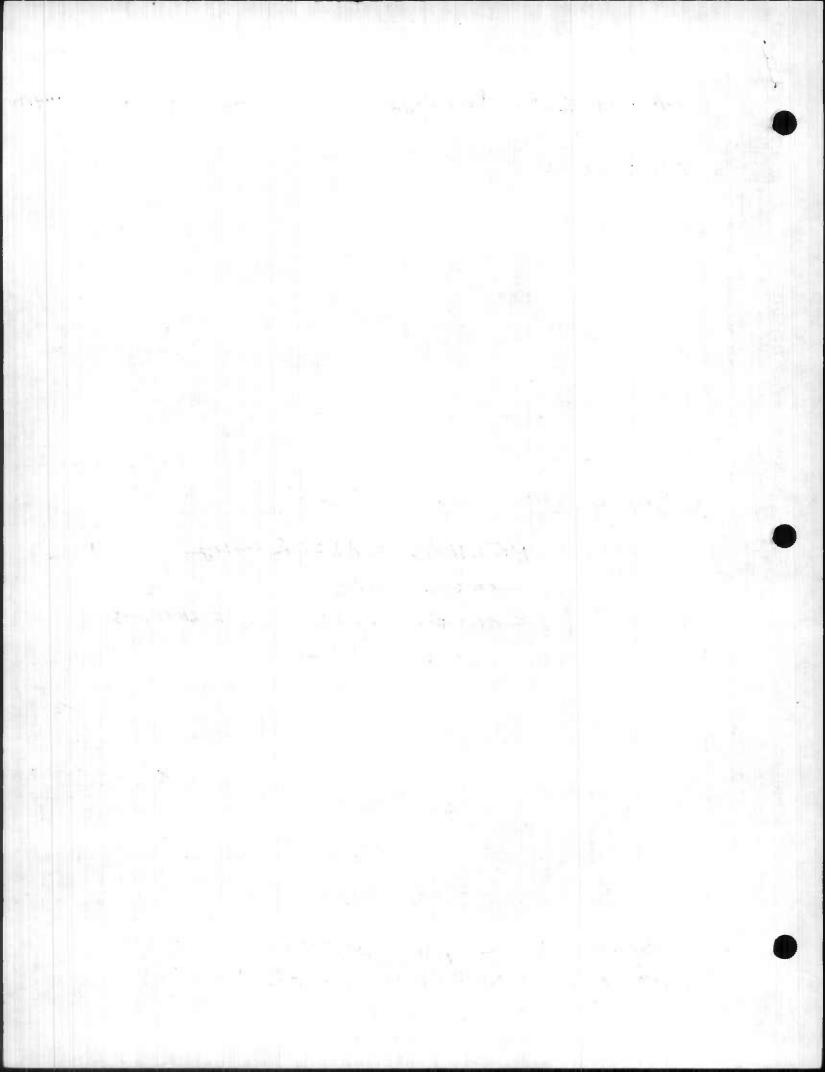
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30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

SYMPMOAK MICHIER RD · 200 N WWW. AVE HDS

Registrar

32. Registrer's Signature



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First Middle Last) 2. Date of Deeth Month 3. Tima of Death Day Year **Physician** Sophie C. Pavloski 2000 1238 P April /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sunbridge Care Center Elkton Cecil If Under 1 Year | If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2\ F Yes 195-05-3142 83 Director NOV 24, 1916 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2□ No Director Pennsylvania Delaware Chester 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 119 Hayes Street 19013 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) flied within 72 h Hygiens. other then "netu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Liquid Filler 8 Chemical permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: if them 27 is marked offer any injury or other the 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) eg Ignatius Kaczyonski Rose Domian 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia Bingnear/Daughter 99 Brownstone Lane, Elkton, MD 21921 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Heart Cemetery 4/6/00 Linwood, PA 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** Metastatic Cancer of Colon /Medical Immediate Cause (Finel years disease or condition resulting in death) Examiner Examiner physician and the burial-tranait Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24e. Wes en eutopsy performed? 1□ Yes 2ENo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 □Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Fatter death. After 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Directompletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sacheler 8 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . SACHDEN MD. 118 North St Swife 3B Eleton MD 21921 32. Registrar's Signeture 31. Date filed (Month, Day, Year)

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Box 68760, P.O.

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Physician

/Medical

Examiner

**Funeral** 

Director

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Department of Health a Important: If frem 27 leany Injury or other tre

**Physician** 

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3 Suicide

4 Homicide

Baltimore, Maryland 21215-0020

Price, Martin

Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifics 24 hours To the Hosp within 24 hor To the Fune completaly fi

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29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steted (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) urtel

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

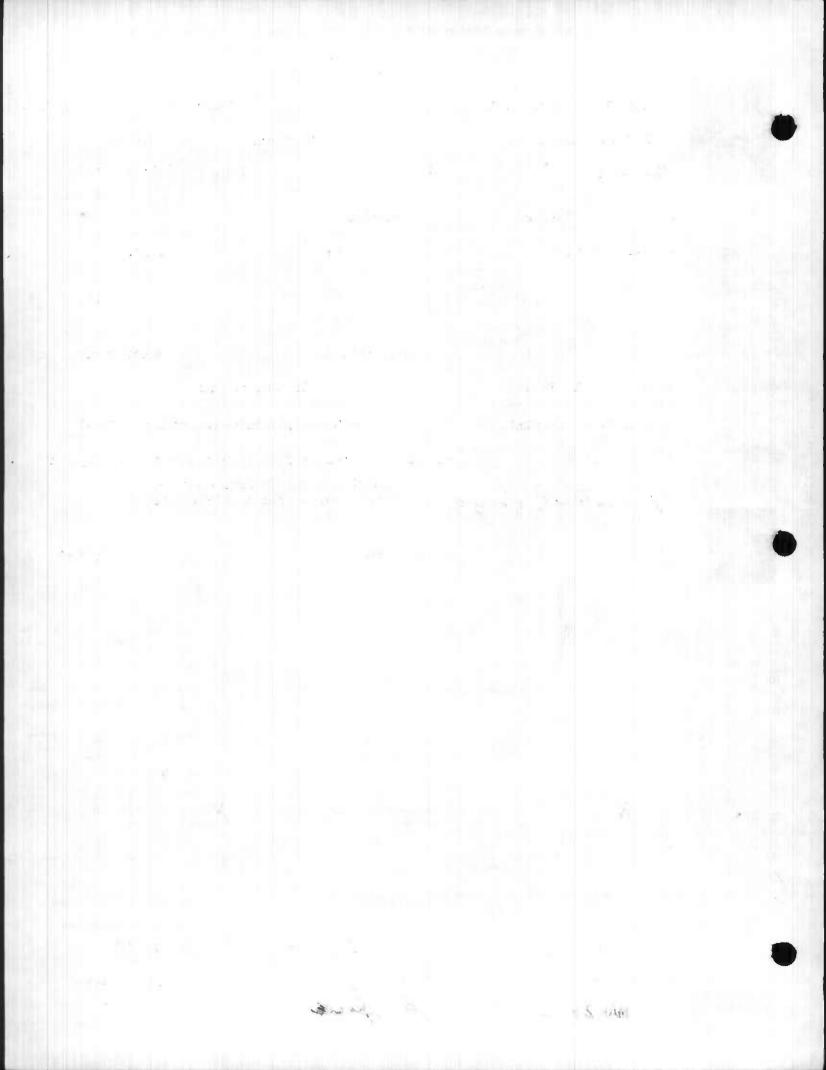
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31. Date filed (Month, Day, Year) MAR 2 9 2000

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Ave BALTIMORE NO 212211 32 Registrer's Signeture

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

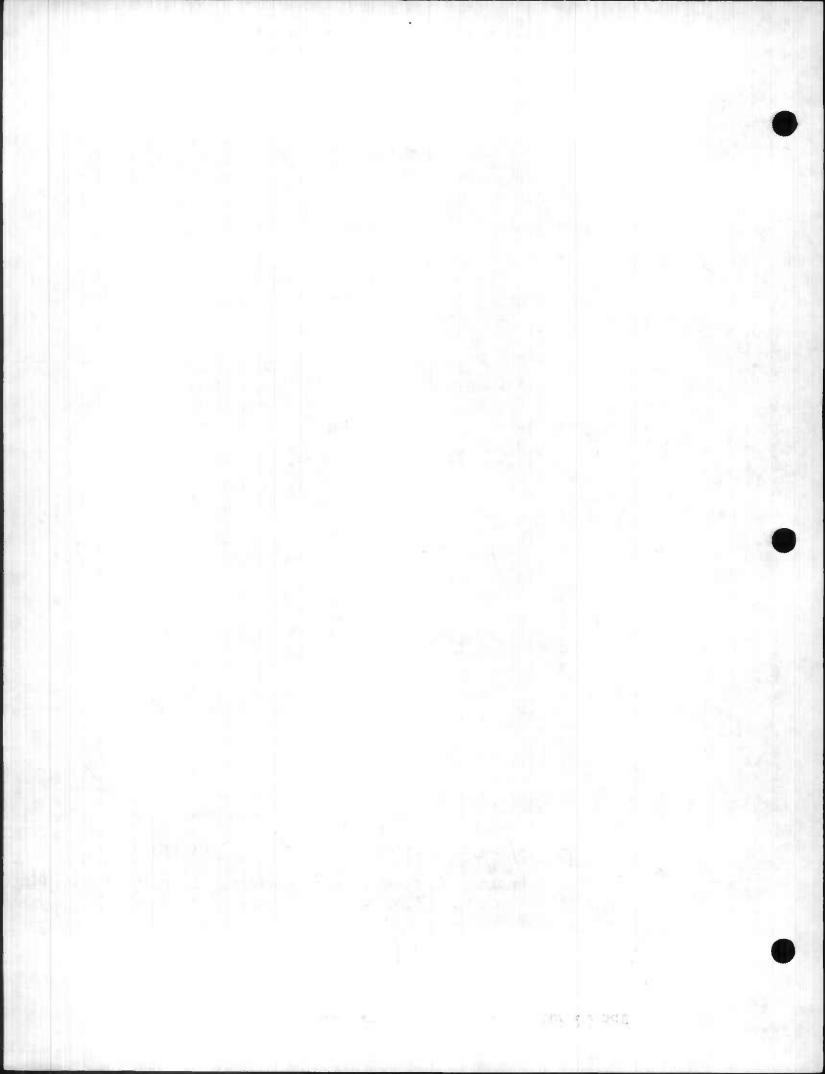


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Certificate of Death	Reg No					

1	Decedent's Name (First Mide														
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1	Maryland Prince George's Upper Marlboro														1 ☐ Yes 2 💢
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ĺ	1 □ Never Married 2 Me		Armed F	orcas?		If	Yas, speci	fy Cuba	in, Mexica	n, Puerto	Rican, atc.)		Bia	ck, White	, etc.
	3 ☐ Widowed 4 ☐ Divorce		If Yes, G	ive		10	☐ Yes 2	No	Specify	<i>'</i> :			Specify	y: [	White
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	19a. Informant's Name/Relation														
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	4 □ Donation 5 □ Other (	(Specify)	)		St. Dem					1	-4-00		Annapo.		
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+	23a. Part1. Enter the disease, of shock, or heart feilure. Lis	or compl	lications that							4'			50	, , , ,	
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01	Immediate Cause (Final disease or condition	st only or	a	Di Di	ulti	onsequi	pence of):	0						) W	Approximate Interval Betwee Onset and Dea
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer Month **Physician** Howard Riche PRINCE 2000 7:50PMMarch /Medical 4a Facility Name (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Deeth Examiner 7105 River Crescent Drive Annapolis Anne Arundel If Under 1 Yeer If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1₽M 2□F Yrs. Director 91 Chattanooga, TN 579-52-8073 Nov. 4. 1908 Usual Residence of Decedent with the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Annapolis Anne Arundel 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 7105 River Crescent Drive Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marifal Status filed within 72 hours after 1 Tyes 2 No 1951— If Nes, Give Year or Dates: 1063 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced white 1962 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene Important; if item 27 is marked other than 'any injury or other traumatic event, the Many injury or other traumatic event, the Many Dices. Elementery/Secondery (0-12) College (1-4or 5+) US Navy OFFICER United States Navy Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Madison Prince Ella Burns Catron 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 River Crescent Dr., Annapolis, MD 21401 Mary Bruce Prince 20b. Place of Disposition (Neme of cometery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/26/00 Fort Lincoln Crematory Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 23e. Pert1. Enter the disease, or complications that caused the Yeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 147 Duke of Gloucester St., Annapolis, MD. Approximate Interval Between Onset and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence ot) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 80 signed by the at 3 be detached for Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records. by 24b. Were autopsy findings available prior to Completed should 24e. Wes an eutopsy completion of cause of death? 1 Yes 2 PNo 1 Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 11-No Certification: To 1 ☐ Inpatient 2 BER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Division or Attending 1 Deatural 5 Pending death. 1 ∏ Yes 2 □ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a, Certifier 1 (Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. To the To the To the F 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Dev. Year)

Registrar

State

2A, Annepolie, MD 2401

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the completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

lidewate

30 Name and address of parson

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death MARCH Physician Pfarr Lena Anna 7:33pm 20,2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEN BURNIE If Undar 24 Hrs. 8. Data of B AA COUNTY ARUNDEL HOSPITAL NORTH GIEN 8. Data of Birth (Month, Day, Year) Oct 5, 1904 If Linder 9. Birthplaca (Stata or Foraign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1□ M 21 F 95 213-28-4599 Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD Anne Arundel Severna Park Director 280-7 10e. Street and Number 10f. Zip Code 21146 10g. Citizen of What Country? herne 23a or 16 St. Andrews Road Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, Whita, atc. 1 Yas 2 No 1 ☐ Nevar Married 2 ☐ Married 8 White 1 Yas 2 No Specify: Specify: à 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 6 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Joseph Contarini Sophia Bosi Pages 1 and 2 should hant of Health and Men 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacqueline A. Chang/ daughter 16 St. Andrews Road, Severna Park, MD If Item 27 Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Malata 24 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from State 2 Baltimore, MD 2000 Lorraine Park Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Sarvice Lie Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Entar the disease, or complications that ceused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Physician /Medical Immediata Causa (Finat diseasa or condition rasulting in death) neumonia hours Examiner Examiner allydra too the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by 1 Yaa 2 No 3 Probably 4 Unknown respiratory Records. þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? After this certificate has 1 Yas 20 No 1 ☐ Yes 2 ☐ No Division of Vitai director, 25. Was casa refarred to medical axaminer? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No funeral 28d. Dascribe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 26b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Matural 1 □ Yas 2 □ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one) 29b. Signatura and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)

State Registrar

MAR 2 4 2000

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signatura G.

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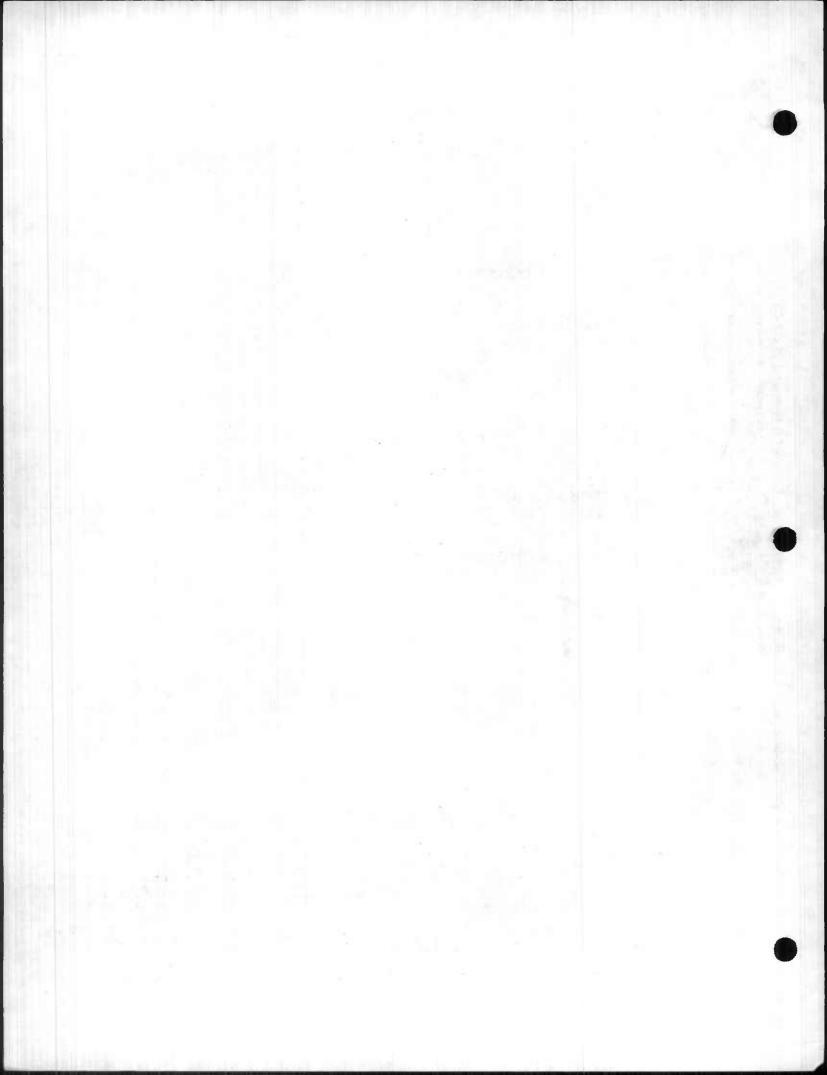
Fig. 1 To Fig. 12 HAM

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** March 29, 2000 12:09am Norman Reynaldo Paredes /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Director 28 August 8, 1971 Maryland 212-11-7659 Usual Residence of Deceder the Maryland 10s. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 ☒ No Directo 288-0 Maryland Montgomery Gaithersburg 10e. Street and Number 10l. Zip Code 10g. Cilizan of Whet Country? ð Serns 23s 20886 United States 9964 Hellingley Place 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2XXNo If Yes, Give Year or Dates: 72 hours after 1EXNever Married 2□ Married 'natural', or 1⊠Yes 2□No Specify: El Salvadorian/Bolivian Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Hispanic Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Had within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Hair Cutting/Styling Geomit. Pages 1 and 2 should be flied village of the pages in the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the pages of the page of the pages Hair Dresser 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surname) 96 Gilda Mazariego Buddy Reynaldo Paredes 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilda Carbonel (Mother) 204 Desellum Avenue, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/1/00 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Causa (Finel disease or condition resulting in death) Examiner Oue to (or as a consequence of) Examine physician and the bural-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to for es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 080 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law page 2200 1 Yes 1 ☐ Yas of Vital 25. Was case referred to medical examiner?
1 No 8 26. Place of Death (Check only ona) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of Injury Wo Mdrch 28, 2000 10:25 P,M. 1 28c. Injury 2 this funeral 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 1 Natural 5 Pending investigation ne Hospital or Attanding in 24 hours after death. The Funeral Director: Afte pletely filled in by the fun 1 Yas 2 0 No Tandina 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be Hellingly Place, Gaithersburg, nome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year)
March 29, 2000 29b. Signeture and title of certified 29c. License number ratticia 5 348, Rockville, MD 20852 Patricia 10ms 31. Data filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Name (First, Middla, Last) 3. Time of Death **Physician** Viola March 22, 2000 4:00 pm Deaver Ouick /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium Health and Rehabilitation Center Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 94 249-03-8957 Director July 6. 1905 S. Carolina Usual Rasidence of Dacedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Anne Arundel Edgewater 1 ☐ Yas 2√ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 211 Oakwood Road Herns 23a 21037 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, atc. after 1 Nevar Marriad 2 Married 1 Yas 2 No Specify:White Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2√ No Specify: à should be filed within 72 hours and Mental Hygiene.

marked other than "natural", o 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Machine Operator Textile 6 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If frem 27 is marked oth-Be Henry Vernon Deaver Alberta Martin 19a. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley McKenzie / daughter 211 Oakwood Road, Edgewater, MD 21037 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Mar 25 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) Dillon, South Carolina Greenlawn Cemetery 2000 22. Nama and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Fustinal Sa Gov. Ritchie Hwy., Severna Park, MD 21146 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immediate Causa (Final Zwhs umonia disaasa or condition rasulting in death) Examiner Examiner ician and burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Diseesa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): physician at the burial Box 68760. Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yee 2 No 3 Probably 4 Unknown signed b à Records, 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 The 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only ona) 1 Yas 2 No Hospitel: Other: Nursing Homa 5 Rasidence 8 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28h Time of 28c. Injury at Work? After 5 Pending invastigation 1 Natural n 24 hours after death.

The Funeral Director: After pletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifie 29c. License numbe DO

**DHMH 16 Rev 6/95** 

State

Registrar

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31. Data filed (Month, Day, Year)

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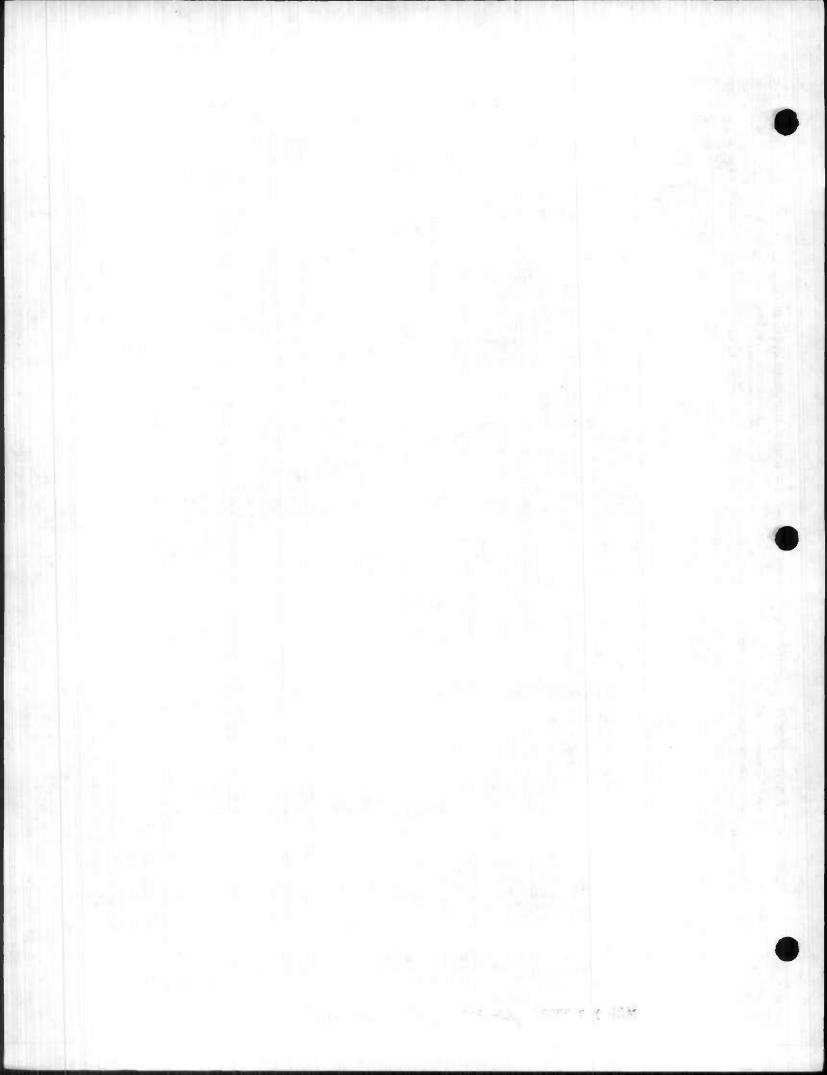
Registrar's Signatura

Annapolls MD

30. Nama and addrass of person who complated cause of death (ttern 23a) (Type, Print)

hambers MD

MAR 2 7 2000



Physician /Medical Examiner

4e Facility Neme (If not institution, give street and number)

Norman

March 28, 2000 4b. City, Town, or Location of Death

10:05 am

1 ☐ Yas 2√ No

**Funeral** 

Birthplace (State or Foreign Country)

Director

Directo 288-1 à Norms 23e natural, or þ Completed the Medical

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21215-0020 Baltimore, Maryland RAISON NORMAN

Box 68760

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Records,

Division of Vital

6 Hospital

PHYSICIAN

KNOWN

**Physician** /Medical Examiner

Examiner sician and burial-transit The law requires that the death certificate be executed physician s the burial Physician/Medical 950 þ Completed page 2 s Attending Physician: Be Certification: To this funeral death. 24 hours after deat Funeral Director:

1 Yes 2 No

5 Pending investigation

6 Could not be

27. Menner of Death

1 Deletural

2 Accident

3 Suicide

4 Homicide

29b. Signeture and title of certified

edical compietely within 2 \$ +IVA

> State Registrar

filled in by

4c. County of Death VA Maryland Health Care System Perry Point
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Days Months MM 2DF 73 Settembee 14,1926 Delaware 218-18-4856 Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 343 East Village 21921 Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 1944 — Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Bleck, Whita, etc. 1 Never Married Merried 1□ Yes 2□ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Bridge Repair 9 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otha Raison Janie Henson 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 East Village Rd. Elkton, Md. 21921 <u>Jeanette Raison (wife)</u> APEIL. 1, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Bohemia Manor Cemetery 2000 Chesapeake City, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Gee Funeral Home 259 E. Main St. Elkton, Md. Approximete Intervel Batween Onset end Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Immediate Cause (Finel disaase or condition resulting in death) Prostate Cancer with Metastasis 4 years Due to (or as a consequence of): Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one)

29e. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one)

28a. Date of Injury (Month, Day Year)

Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

29c. License number D16608

28c. Injury at Work?

1 Yes 2 No

29d. Data signed (Month, Day, Year)

28t. Location (Street end Number or Rural Route Number, City or Town, State)

March 28, 2000

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

(an 30. Name end address of person who completed cause of death Item 23a) (Type, Print)

KAM-KEN LEUNG, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Dete tiled (Month, Day, Year)

MAR 3 0 2000 32. Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month 2000 A: 30 PM RISTAINO ISABELLE 03 30 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Arundel Medical Center Arunde Anne Annapolis 5. Social Sacurity Number 6. Sax Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Nov. 20, 1916 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days Hours 1 M 2 X F 212-05-0333 83 Maryland Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 737 Baltimore-Annapolis Blvd. USA 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Detes: 1 ☐ Yas 2 ☐ No Specify. 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) James William Barnes Susan Schaeffer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5420 Beach Dr. Carol R. Baker / daughter St. Leonard, MD 20685 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burlal 2X Cramation 3 ☐ Ramoval from State Ft. Lincoln Crematory 4-1-00 Brentwood, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funaral Sarvice Licens 147 Duke of Gloucester St. Annapolis, MD 21401 due ran 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death Cerebellar Hemorrhage Immediata Causa (Final diseese or condition resulting in death) Dua to (or as a consequence of) Due to (or as e consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atherosclerosis 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 1000 1 ☐ Yas 2 ☐ No

**Physician** /Medical **Examiner** 

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page 2

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24 hours after deal Funeral Director:

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Hospital

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The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital or Attending Physician: Physician

/Medical

**Examiner** 

**Funeral** 

Director

to be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death wi Department of Health and Mental Hygiane. Important: If them 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, its Medical Examines must

altimore, Maryland 21215-0020

Director

by Funeral

Completed

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Physician/Medical Examiner

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Medical Certification: To

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26. Place of Death (Check only one)

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

6 Could not be data mined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

29a, Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year)

1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

30. Nama and addrass of parson who completed cause of death (ttam 23a) (Type, Print) 4000 mitchelluille Rd. Svite 116 Bowne, MD 20716

Hospital:

03/30/00

State Registrar

31. Data filed (Month, Day, Year)

25. Was casa referred to medical axaminar?

1 Yes 2 No

27. Menner of Daath

1 Netural

2 Accident

3 Suicide

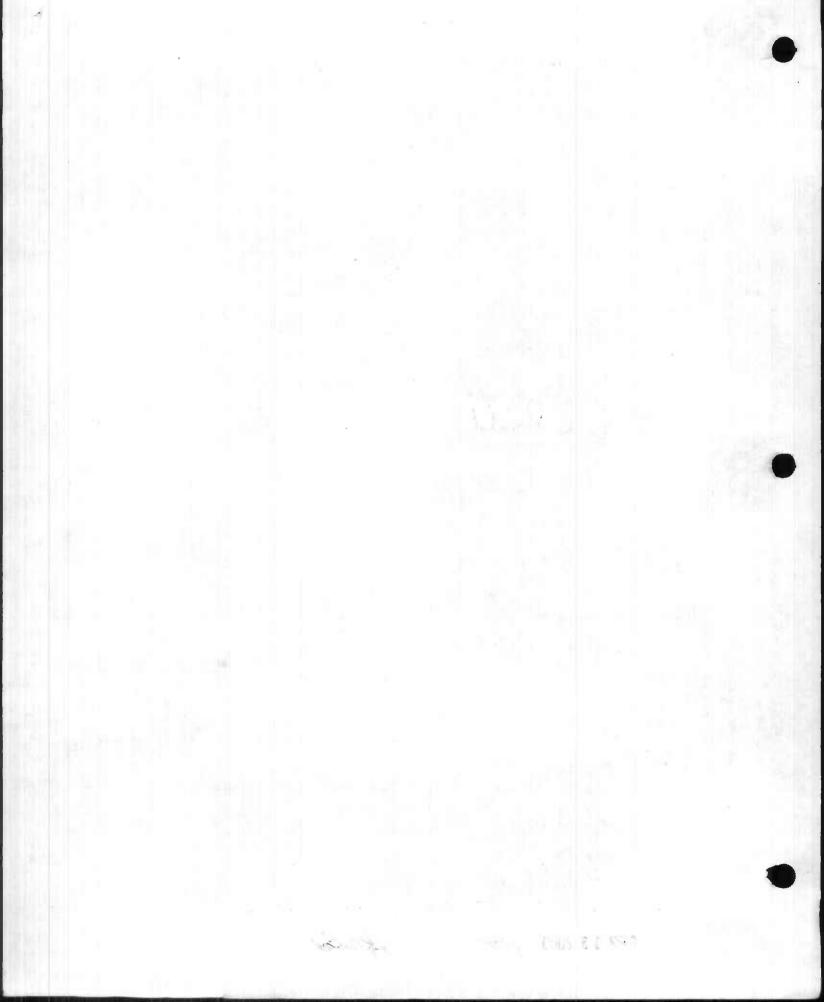
4 Homicide

APR 03 2000

SEJAL MATTI

5 Panding invastigation

32./Registrar's Signatura



				Cert	ificate	of Death		Reg. No.		
	1. Decedent's Nama (First, Middla, L.			2. Date of De	ath		3. Time of Death			
Physician	EDNA VIRGINI	A ST	CACKH	OUSE			MARCH	29 200	Year	6:09am
/Medical Examiner	4e Facility Nama (If not institution, gi					4b. City, Town, or	Location of Death			o.obam
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Funeral			ga (In yrs. la		If Under 1 Y	ear If Under 24 Hr	s. 6. Data of Birt	h		lace (Stata or Forei
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or 24	10e. Street and Number				10f. Zip Co	de		10g. Citizen of V	Vhat Count	try?
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dea - dea	11. Marital Status	12. Was Deceden Armed Forces	Ever in U,S	13. W	as Decedent	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yas or No	14. Rac	e - Amarica k, White, e	
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Department important: If any injury or phose.	21. Sapraturing Funeral-Service Lice	nsee		Cal		ddress of Facility Funeral	Wome of	Chanh		ahnaah
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he Funeral pletely filled edical C			of axamination			ne tima, date and pled my opinion, death occ				
To the comple			igation, in my opinion, death occurred at the tim			29d. Data signed (Month, Day, Year)				
5.00	290. Signatura and titla of certinar				29c. Li	cense number		29d. Data signa	d (Month I	Dav. Year)
N C O	29b. Signatura and titla of certifiar  Monte Ma	MA MA			29c. Li	D- 44783		29d. Data signe 3-29 -		Day, Year)

State Registrar 31. Data filed (Month, Dey, Year)
MAR 2 9 2000

Monte Makous, MD

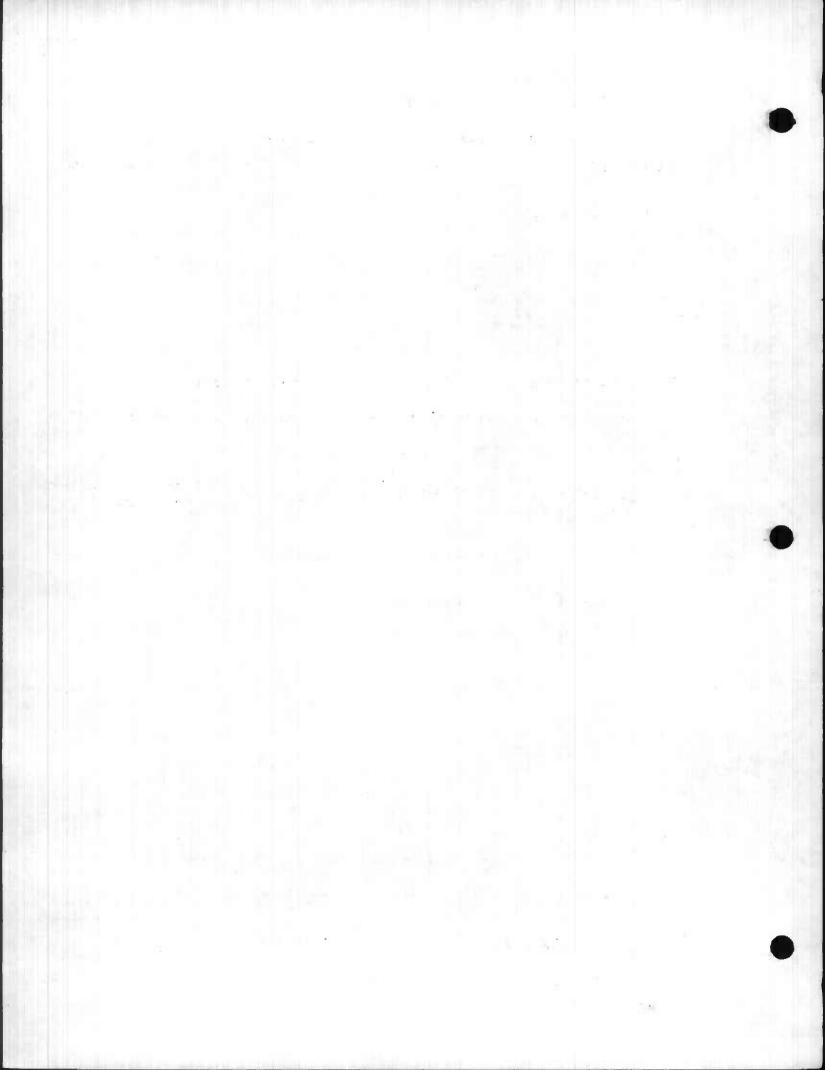
32. Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sports

111 West High St. Elkton, MD. 21921

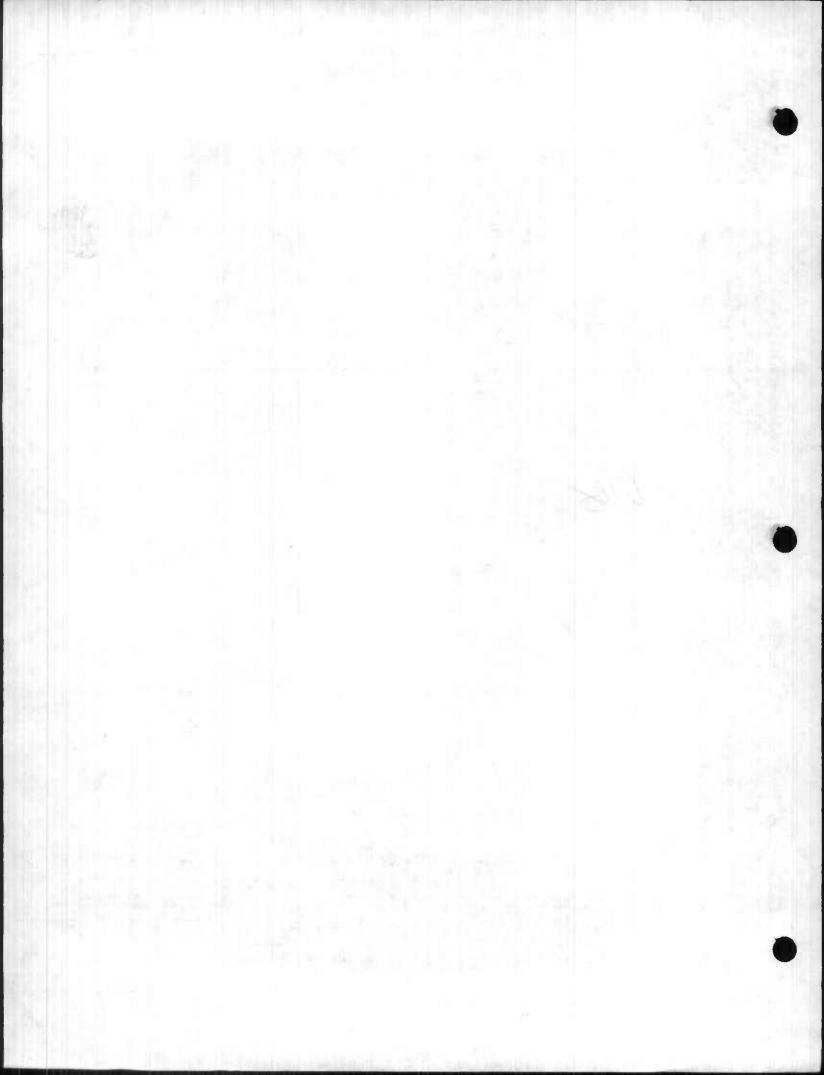
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				Otato of Iviaryia		tificate of			eg. No.		1905
п	Physic	ian	1. Decedent's Name (First, Middla, Last)					2. Date of Dear Month	th Day	Year	3. Time of Deeth
	/Medi		Germaine Mary	Simoson					29, 200		8:30 AM
ħ.	Exami		4a. Facility Name (If not institution, give s				4b. City, Town, or L	ocation of Death	4c. County	of Death	
			265 Foster Knoll	Drive			Joppa		Harfo	rd	
	Funeral Director		207 22 3020	7. Age (In yr.	s. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day Sept 29	Year) 9, 1911	9. Birthpli Count Ital	ace (Stete or Foreign try)
	pg &		Usual Residence of Decedent  10a. State 10b. County	100 (	lity. Town or Loc	entine				7	
	e Maryla	ctor	Maryland Harford		Joppa	ation				10	od. Inside City Limits 1 ☐ Yas 2 No
	th with th	ai Director	10e. Street and Number 265 Foster Knoll	Drive		10f. Zip Coda	21085	1	0g. Citizen of V USA		ry?
020	d within 72 hours after death with the Maryland jiene. I than "natural", or itema 23a or 28e-f show than Wodical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Nevar Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedant Evar in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedant of Yes, specify Cul	Hispanic Origin? (Sp ban, Maxican, Puarto Specify:	pecify Yas or No- Prican, atc.)		e - America k, White, e :: Wh	
21215-0020	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a <i>completed)</i> College (1-4or 5+)	life. D	ent's Usual Occu kind of work done O NOT use retire	pation a during most of work ad)	ring	16b. Kind of Bu		ustry
7	73 75 10		17. Father's Name (First, Middle, Last)				18. Mother'a Nam	a /First Middle I			
Maryland	ould be Mental arked o	o Be	Henri (UNK) Fronze	oni				ne (UNK)		,	
2	2 should be and Menta is marked aumatic ex	To	19e. Informant's Name/Relationship (Tys		19b Mailing	Address (Stree	et and Number or Rui				Code
	od 2 ith ar 27 is		Joan A. Siegel/Day				Moll Driv			21085	5030)
Baltimore,	permit. Pages 1 and 2 should be files Department of Health and Mental Hys Important: If item 27 is marked othe any injury or other treumatic event, once.		20a. Method of Disposition			iltion (Neme of etory or other ple			20c. Location -		wn, State
OE.	age ent o nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Spring)			etory or other pil .vet Cem		/3/00	Carvert	on I	DΔ
Ħ	artm ortar injui		21. Signature of Funeral Service License	9		Name and Addr		/3/00	CULVCIC	OII, I	. 23
ä	Depa Impo any i		DIL UNI	12 #	_ 110	Comas F	uneral Ho				
	-		23a. Part . Enter the distress or compare	cations that caused the dec	Hth. Do not ente	317 Coke of dv	sbury Road	d, Abing	don, M	2100	Approximata
4	Physician		shock, or heart failure. Elist only on	trease on each line.		,			,		Interval Between Onset and Death
	/Medical		Immediate Cause (Finat	1 + R	.0	1/2 0	ar Acci	0 +			H L
	Examiner		disease or condition resulting in death)	Due to	(or as a consequ		1000		_		1 unules
	D 55	ner		343.19	(0. 40 4 00.1004)	30100 017.				1	
	ifficate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions,	. Due to	or as a consequ	ience of):					
ò	slan a	Ü	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events							- 1	
68760,	sate t	edicai	that initiated events resulting in death) Last	Dua to (	or as a consequ	ence of):					
	E 0 0	-	d								
Box	attendir for use	ian		•							
o.	the a	Physician/N	Part II. Other significant conditions conf	tributing to death but not re	sulting In the un	derlying cause g	iven in Part I.	23b. Dld to	bacco use co	ntribute to	the cause of death?
P.O.	requires that the death cer seen signed by the attendir hould be detached for use		Parkingson ?	lessas				1 🗆 Y	98 20 No	3 Prob	ebly 4 Unknown
ds,	w requires that been signed should be det	d by		J				270 MIC 2	0/10/2/2020	OAh Ma	
Ö	nedu	Completed	- Hysertensian					24a. Was a perform		ava	re autopsy findings llable prior to apietion of cause
ě	8 5 0	id m	01	•						of d	leath?
<u>=</u>			Dialetes Mel	litus				1 □ Ye	es 25 No	1 🗆	Yes 2□ No
=======================================	ysician: The li s certificate he director, page	Be	25. Was case referred to medical exeminer?	ospital:		l O	26. Place of Deal				
ō	두 도등	T.	1 ☐ Yes 2 No	1 L Inpatient 2L	ER/Outpatient	3LI DOA		me 5 Reside			)
5	After After fune	ion	1 Natural 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ork? Yes 2 \( \subseteq No	28d. Describe ho	ow injury occuri	90	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At building, etc. (Spec	noma, farm, stre			28f. Location (St City or Town	reet end Numb n, Stete)	er or Rural	Route Number,
	Hospita 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one)  2 Medical Examin	ictan: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the ti estigation, in my	ime, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) end ma ate and piace,	nner as sta and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of continue	and mainter stated.		29c, Lican	sa number	2	9d. Date signed	i (Month. D	Day, Year)
	F 3 F ŏ		111-1	11/	1	7	CONI		3-29		
			20 Name and address	11. Wood	- 00-1/2		30040		3-61	- 00	
			30. Name and address of person who cor	mpleted cause of death (Ite	m 23a) (Type, P	6 0	neuman	MD	2104	0	
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registrars Sign		/,	1		7		
	Sla		MAR 3 0	2000 N Day	Land	14 1	2				

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Stanley Everett Skillin March 29, 2000 4:00 am /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 8101 Rider Avenue Towson Baltimore 5. Sociel Security Number 6. Sex 1₽ M 2□ F If Under 1 Year if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) June 29, 1907 Boston, MA 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Deys 034-22-5179 Vrs 92 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 No Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8101 Rider Avenue 21204 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Retail & Domestic Elementary/Secondery (0-12) College (1-4or 5+) 12 Oil Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Everett Skillin Emma Carruthers 19e. Informent's Neme/Reletionship (Type, Pnint) Daughter 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara S. Walcher 8101 Rider Ave., Towson, MD 21204 20a. Method of Disposition 20b. Piece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete Dete 1 ☐ Bunei 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Cambridge Crematory 3-29 Cambridge, MD 22. Name end Address of Fecility
Curran-Bromwell Funeral Home, P.A. 21. Signeture of Funerei Strvica Licensee 308 High St., Cambridge, MD 21613 somwell Enter the disease, or composal on sthet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervei Between Onset and Death Immediete Ceuse (Finel Sepsis diseese or condition resulting in deeth) Due to (or es e consequence of): Examiner Prostate Cancer meta static years Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequenca of): Physician/Medical Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 KNo 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) D30182 29,2000 MARCH 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) WILLIAM RUSSELL 8900 WALTHER BLUD BALTIMORE MD 21234 MD 31. Dete filed (Month, Day, Year)

State Registrar

**Funeral** 

Director

the Medical Examiner

Baltimore, Maryland

Peges 1 and 2 should be nent of Health and Mental

nt of Health a: If item 27 is

Department of important: If any injury or

**Physician** /Medical

Examiner

physician

ate has been signed by the ettending page 2 should be detached for use.

certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; p

the

The law requires that the death certificate be executed

Box 68760.

P.O.

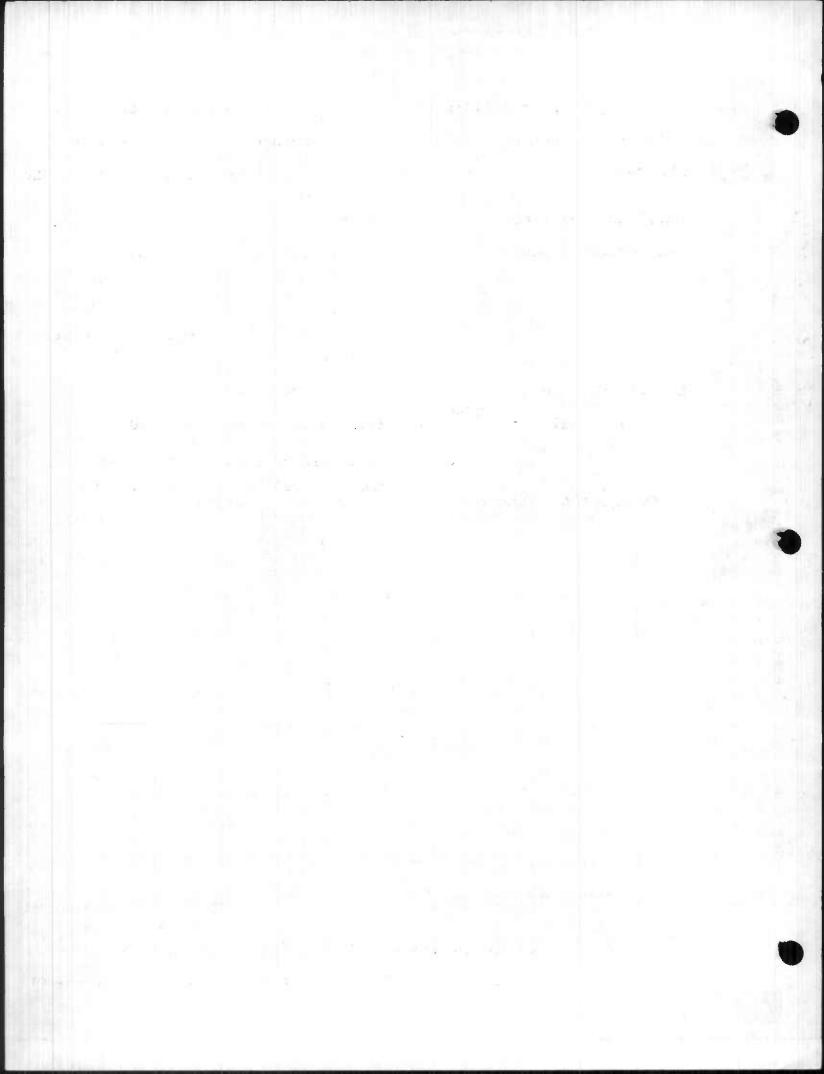
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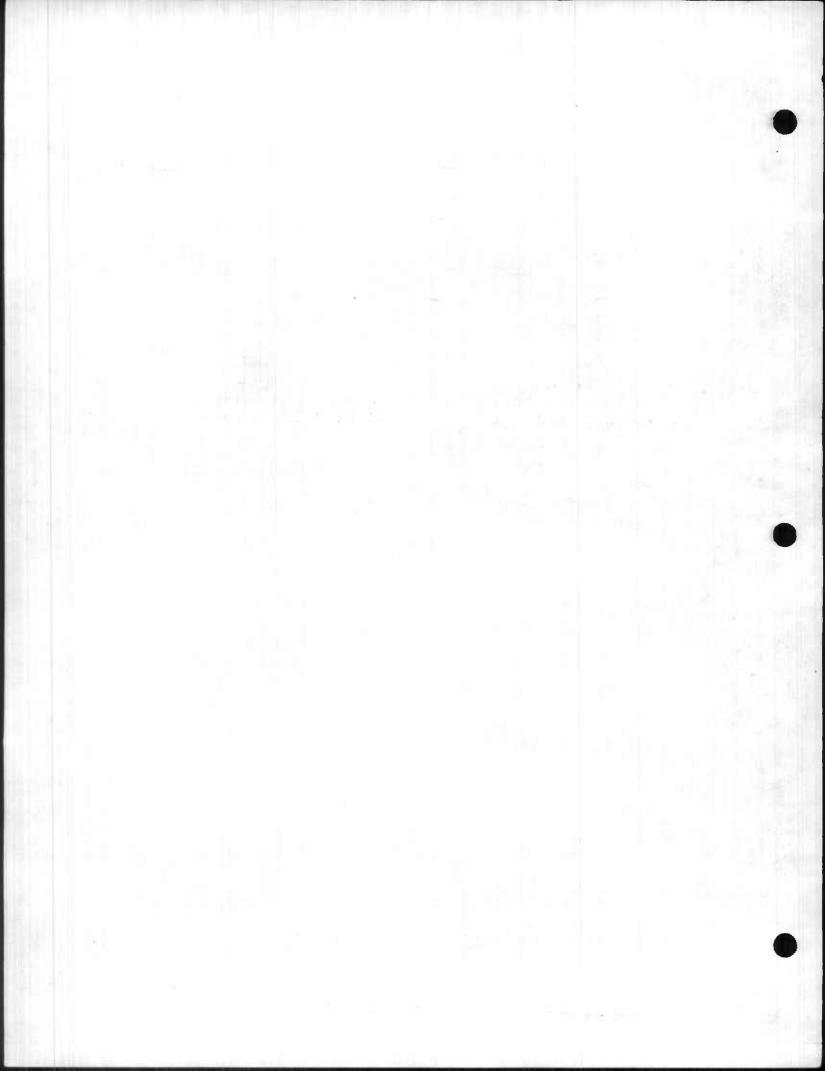


Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1988 AMEND# 8, 12 AACO Health CMH 4/6/00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Year Month **Physician** Charles Pau1 Sheppard 30 8:00 PM 2000 March /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center | If Under 24 Hrs. | 8. Date of Birth | 1.9 18 | Month, Day, Veal' | 18 | Sept. | 15 | 1916 If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months 1♥M 2□F 457-14-7947 Yre 81 83 Director Texas Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show 1 ☐ Yes 2X No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 TR 238 1136 Mainsail Drive 21403 USA deeth Funeral Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Herra 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. 7 is marked other than "natural", or iten traumatic event, tra Medical Experient filed within 72 hours after 1 Never Married 2 Married 1 X Yes 2 No 72 Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1941—73 1 ☐ Yes 2 ☒ No Specify: Specify: Aq 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Officer U.S. Navv permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If them 27 is marked oths any Injury or other treumatic event 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Chester C. Sheppard Minnie Vera 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary (Marie) Sheppard F136 Mainsail Drive 21403 Annapolis, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4-4-00 St. Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signeture of Funeral Service Licent 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** coronary auteur disease Yeavs /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Be Completed 24a. Was en eutopsy hes certificate 1 🗆 Yes 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Certification: To 3X DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kd. Annapolis, mo 21401 900 selonick. 31. Dele filed (Month, Day, Year) 32, Registrer's Signature State Registrar APR 0 3 2000

ORIGINAL



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1999

_	Decedent's Neme (First, Middle, Las.	a k	С	ertificate of	Death	2. Date of De	Reg. No.	2 Time of Date		
Physician /Medical	William	J.	<	Sams		Month	Dey	Yeer 4:15 P.		
Examiner	4e Facility Nema (If not institution, give				4b. City, Town, or L	ocation of Deat	h 4c. County	of Death		
	725 Bayard R			If Under 1 Year	Lothian H Under 24 Hrs.	_		Arundel		
Funeral Director	5. Social Security Number 409-70-4667  Usual Residence of Decedent	XM 2□ F 58	yrs. last birthda Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Feb. 2	ay, Year)	9. Birthplace (State or For Country) Tennessee		
a dem	10a. Stele 10b. County	10c.	City, Town or	Location	11.1			10d. Inside City Lir		
or 28a-fs be notified Director	Maryland Anne Aru	ndel	Lo	thian				1 ☐ Yes 2 ][0		
23a or 2 ant ban ai Dire	10e. Street and Number 725 Bayard Road			10f. Zip Code 207	11	. 1	10g. Citizen of W			
"natural", or items 23e or 28e-f show adical Examiner must be notified at leted by Funeral Director	11. Meritel Stetus  1 Never Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 Yes 24 No if Yes, Give Yeer or Detes:	n U,S. 1	3. Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 ANo	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	e-American Indien, k, White, etc. White		
A tra matural of the Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12)	le completed) College (1-4or 5+)	(G	cedent's Usual Occupive kind of work done  b. DO NOT use retire	during most of world)		16b. Kind of Bu			
other to vant, to Se Co	17. Father's Neme (First, Middle, Last)	12th	Sto	ne and Mar			Constru			
marked othe metic evant, To Be C	Herbert	Sams				lizabeth		6)		
E	19a. Informent's Neme/Reletionship (T	ype, Print)	19b. Me	eiling Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip Code)		
Kem 27	Ann E. Sams/ Wi		725	Bayard Ro	oad Loth	ian, MD				
7 0 0	20a. Method of Disposition  1 🕅 Burial 2 Cremetion 3 🗆 6  4 Donetion 5 Dother (Specify,	Removel from Stele	cometery, of the comptery, of the compte	sposition (Name of cremetory or other places to Cemeter)	ce)	4-3-00	OO Annapolis, MD			
important: any injury once.	21. Signature of Funeral Service Ligensee  22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater									
/sician	23e. Pert1. Enter the diseese, or comp shock, or heart feilure. List only o	ne ceuse on each line.	leeth. Do not	enter the mode of dyi	ng, such as cerdiac	or respiretory e		Approximete Interval Between Onset and Deeth		
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physician and s the burlat-transit rdical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Due t	o (or as e con:	sequence of):						
_ = =	that initieted events resulting in death) Last	Due to	o (or as e cons	sequence of):						
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ed by the attending detached for use a Physician/M	Port II. Other significant conditions co	ambuing to death out not	resulting in the	a underlying cause gr	ven in Penti.		23b. Did tobecco use contribute to the cause of de 1 Yes 2 No 3 Perobably 4 Unk			
sate has been signed page 2 should be de Completed by P								24b. Were autopsy tindin available prior to completion of cause of death?		
te has						10	Yes 2 No	1 ☐ Yes 2 ☐ No		
s certificate hadirector, page	25. Wes case referred to medical				26. Place of Dea	th (Check only	one)			
this ceral direction.	axeminer? 1 ☐ Yes 20 No	Hospilel: 1 ☐ Inpatient	2 ER/Outpal	tient 3 DOA	her: 4 Nursing H	ome 5□ Res	idence 6 Othe	ar (Specify)		
	27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Yea	28b. Time Injur	y Wo	nyat rk? IYes 2 ∐ No	28d. Describe	how injury occurr	ed		
	3 Suicide 6 Could not be determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Funeral Dir completely filled in Medical Cert	29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exam end menner steted.	knowledge, de ninetion end/or	eth occurred at the ti investigation, in my	me, date and place opinion, deeth occu	, and due to the rred et the time,	cause(s) and ma date end plece, a	nner as stated. and due to the cause(s)		
Ne Me	29b. Signeture and title of certifier			29c. Licen:	se number		29d. Date signed	i (Month, Day, Year)		
	Illenine w	eno, MD		D5	2830		march	31, 2000		
	30. Name and address of person who co	ompleted cause of deeth (	Item 23a) (Typ	pe, Print)	Prod C :	1,2~	A	1 (Month, Day, Year) 31, 2000 111, MD 21		
State	31. Dete filed (Month, Dey, Year)  APR 0 3 200	32. Registrer's Si	gneture	1 day	1 - 301	,	1 1 NOV	ال دار دار		

-54,2004 - - 2000 2 2 2003

				Cer	tificate of	Death		Reg. No.	J 11990 ·
	ne (First, Middle, L						2. Date of D Month	Day	Yeer 3. Time of Death
		hifanella				th Chy Town or	March		000   10:15 PM
		ive street and numb				4b. City, Town, or			
Ann apo L  5. Social Security		ng & Reha	Age (In yrs. I		If Under 1 Year	Annapol:			Arundel  9. Birthplace (State or Foreign
215-38-7		1∏M 2□F	79	Yrs.	Months Days	Hours Min.	(Month, D	21,1921	New York
Usual Residence							TCD. 2	-1,1/41	New TOLK
10a. State	10b. County		10c. City	, Town or Loc	ation				10d. Inside City Limits
MD	Anne A	rundel		Annapo!	lis				1 No Yes 2 No
10e. Street and No	mber				10f. Zip Code			10g. Citizen of V	Vhat Country?
114 S	pa View A	Ave.			2140	1		US	SA
11. Marital Status		12. Wes Decede Armed Force			es Decedent of H Yes, specify Cub	lispanic Origin? (S an, Mexican, Puar	Specify Yes or N to Rican, atc.)		e - American Indian, k, White, etc.
	ried 2 Married	1 Yes 2 If Yes, Give		1	☐ Yes 2 No	Specify:		Specify	
3 LI WIGOWEG	4 Divorced	Year or Date	es: WW I			and a second			WILLE
	15. Decedent's E cify only highest gr	rade completed)		(Give I	ent's Usual Occup and of work done O NOT use retire	during most of wo	rking	16b. Kind of Bu	isiness/industry
Elementary/Sec	ondary (0-12)	College (1-4	or 5+)		cords Cl			Coı	urthouse
	(First, Middle, Las	st)					me (First, Middle	e, Maiden Sumam	
Giusepp	e Schifar	nella				Laudom	ia Casa	anova	
	lame/Relationship			19b. Mailing	Address (Street			ber, City or Town,	State, Zip Code)
Antoinet	te Schifa	anella/Si	ster	114	Spa View	Ave,	Annapol:	is, MD 2	21401
20s. Method of Dis		DECC 1	- 00	ace of Dispos	ition (Name of etory or other ple	oe)	Dete	20c. Location -	City or Town, Stete
	5 Other (Special	□Removel from St ify)	919		ln Crema		-25-00	Brentwoo	od, MD.
21. Signature of F	uneral Service Lice	enseg	V =	22.	Nama end Addre	ss of Facility Jo]	hn M. Ta	aylor Fur	neral Home, Inc.
P	Ri	D	00						lis,MD 21401
23a. Part 1. Enter	the disease, or cor	nplications that cau	sed the doubth						Approximete Interval Between
and, or no	ir remore. Cost orny	y 0110 02030 011 000	al into.						Onset and Deeth
Immediate Cause disease or conditi	on	. (	a (	0601	V				18 mor
resulting in death)		d.	Due to (or	es a consequ	uence of):				
		b							-1
Sequentially list of it any, leading to it cause. Enter Und	onditions, mmediate		Due to (or	as a consequ	ience of):				
cause. Enter Und Cause (Disease of that initiated even	erlying r injury	c							
resulting in death)	Last		Dua to (or	as a consequ	ence of):				
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Part II. Other elem	ficant conditions	contributing to deal	h but not recu	Iting in the un	deriving cause of	en in Pert I	23h Die	f tohacco use cor	ntribute to the cause of death?
valor ergit		July 10 0081	550 1100 1830	and at the other	authrig cause gn	O. 1 11 1 OIL 1.		Yes 2 KNo	3 Probably 4 Unknown
									- Living of the control of the contr
								s an eutopsy lormed?	24b. Were autopsy findings available prior to
							pen	onnou i	completion of cause of death?
							10	Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case refe	rred to medical					26. Place of De	ath (Check only	one)	
examiner?	No	Hospital:	atient 2 2	ER/Outpatient	3 DOA OH	oc.		sidence 6 Othe	er (Specify)
7. Manner of Dea	th 5 Pending	28a. Dete of (Month,		28b. Time of Injury	28c. Injui		1	how injury occurr	
2 Accident	investigation	on				Yes 2 □ No			
3 Suicide	6 Could not l	288. Place of	Injury - At hor, etc. (Specify,	me, ferm, stre	et, fectory, office			(Street and Numb own, State)	er or Rural Route Number,
4 Homicide									
	127 0-44 1	hysician: To the be	s of examineti	rledge, death on end/or invi	occurred at the tirestigation, in my o	ne, date end place pinion, death occi	e, and due to the urred et the time	e cause(s) end me e, dete end place, i	enner as stated. and due to the cause(s)
29a. Certifier (Check only	2 Medical Exa		steled.						
29a. Certifier (Check only one)	2   Medical Exa	and manne			20c Licens	a number		29d Date signs	d (Month Dev Veer)
29a. Certifier (Check only	2   Medical Exa	and manne			29c. Licens	a number		29d. Date signed	d (Month, Day, Year)
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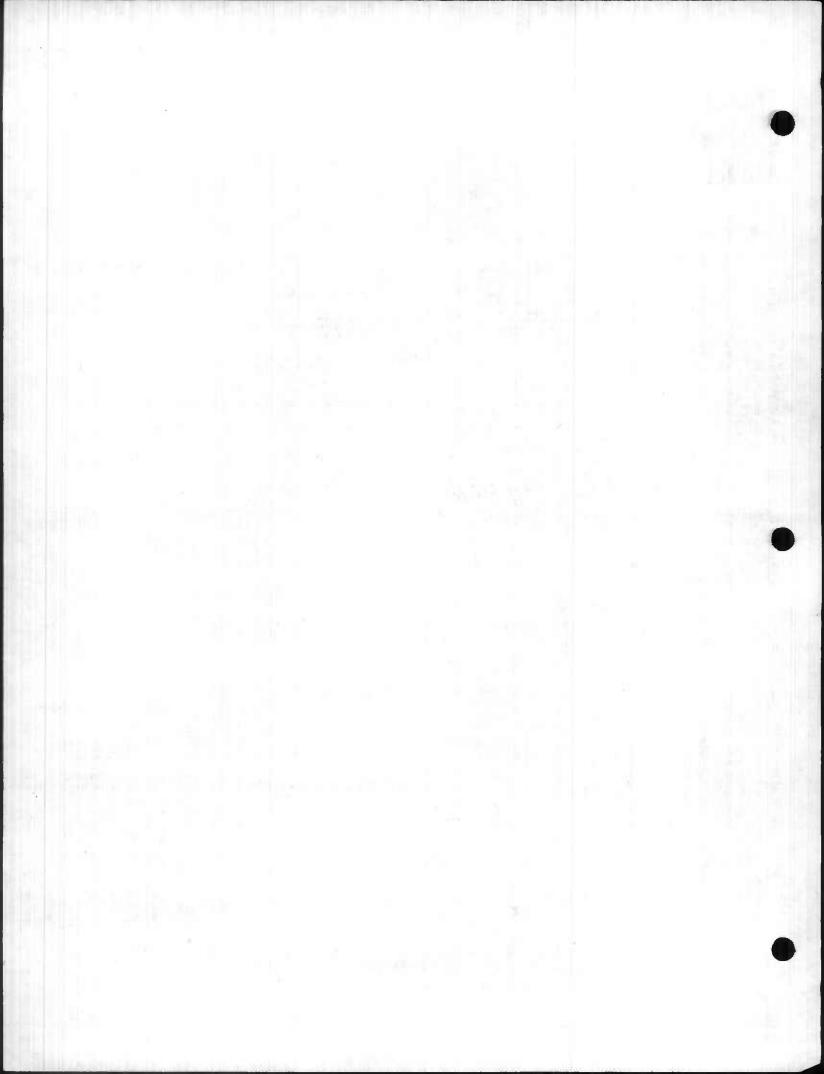
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O.O.

Act her rine H. Talley  Union Hospital 5 & Sex Sex Sex Sex Sex Sex Sex Sex Sex Sex	Dhorisian	I. Decedent's Name (First, Middle, Last)	Cer	tificate of De	2. Date of D	Reg. No.	3. Time of Death	
Union Hospital  S. Social Security Number  1 December 1				4b. C	HONSI	2 20	00 /121	
Scientification Number    1	Examine							
179-24-1333   89   71	Funeral	Social Security Number 6. Sex		If Under 1 Year   If U	Inder 24 Hrs. 8. Date of Bi		Birthplace (State or Fore	
DE New Castle Bear 10/. Zp Code 100, Zp Code		179-24-1333	2\(\text{Y}\) F 89 Yrs.	Months Days He				
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Second   Process   Part of Dates   Part of D	ra int	409 Pencader Lane						
17. Father's Name (First, Middle, Lash)   18. Mechan's Name (First, Middle, Mandon Sumanne)   19. Mediting Address (Street and Number or Russ House Number. City or Town, State, Zip Code)   19. Informer's Name-Priedicinnship (Type, Print)   19. Mediting Address (Street and Number or Russ House Number. City or Town, State, Zip Code)   19. Informer's Name-Priedicinnship (Type, Print)   19. Mediting Address (Street and Number or Russ House Number. City or Town, State, Zip Code)   19. Informer's Name Priedicinnship (Type, Print)   19. Mediting Address (Street and Number or Russ House)   20. Location City or Town, State, Zip Code)   19. Russ (Street and Number or Russ House)   20. Location City or Town, State, Zip Code)   19. Russ (Street and Number or Russ House)   20. Location City or Town, State, Zip Code)   20. Location (State)   20. Loca	in a	1 Never Merried 2 Merried 1	Yes 2 No				Vhite, etc.	
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Pavid C. Poffenberger   Margaret Greene   Margaret Greene   19e. Informent's Hamm-Riedicionahip (Type, Print)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19e. Informent's Hamm-Riedicionahip (Type, Print)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimp Address (Street and Number or Fural Route Number, City or Town, State, Zp Code)   19th Assimption Route of Part of Number of Part Num	B 8 0	7. Father's Neme (First, Middle, Last)			Mother's Neme (First, Middle			
T. Scott Bullock — son  206. Method of Disposition  206. Method of Disposition  206. Piece of Disposition (Name of Disposition (Name of Disposition (Name of Disposition) (Name of Disposition)  21 Signified of Linguist Syring Licentified (Piece)  22 Sequentially in conditions  23 Sequentially in conditions  24 Disposition (Name of Disposition) (Name of Disposition)  25 Sequentially in conditions  26 Disposition (Name of Disposition) (Name of Disposition)  27 Sequentially in Conditions  28 Disposition (Name of Disposition) (Name of Disposition)  29 Disposition (Name of Disposition) (Name of Disposition)  20 Disposition (Name of Disposition) (Name of Disposition) (Name of Disposition)  21 Signified (Name of Disposition) (Name of Disposition) (Name of Disposition)  22 Disposition (Name of Disposition) (Name	Meri affice To	David C. Poffenberge	r	Ma	argaret Green	e		
20b. Memod of Disposition   Date   20b. Location - City or Town, Stete   20b. George of Disposition (Name of complete, commentary or other places)   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   21. Signal of Engage of Disposition (Name of Complete)   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   21. Signal of Engage of Disposition (Name of Complete)   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4/6/2000 New Castle, DE   Description   Crace Lawn Mem. Pk. Ceme. 4	Is m raum			g Address (Street and I	Number or Rural Route Number	ber, City or Town, Sta	te, Zip Code)	
10 Burel 2   Ceremeton 3   Remove from State   A   Castle, DE   Crace   A   Comments of Bother (Speechy)   Crace   A   Comments of Bother (Speechy)   Crace   A   Comments of Bother   Comments of B	m 27 her t						Town Original	
21. Signated of Fungers Service Lichites  Frank C. Mayer, Jr.  22. Name and Address of Facility  Spicer Mullikin Funeral Home  1000 N. DuPont Hwy. New Castle, DE 19720  Approximate infendence of completations that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate infendence of completations that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate infendence of completations that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate infendence of completion or resulting in death) I as a consequence of the cause of conditions.  Due to (or as a consequence of):  Due	y or of	1X Buriel 2 ☐ Cremetion 3 ☐ Remo	vel from State cemetery, crem	netory or other place)				
Saguentially list conditions, any lease of conditions contributing to death but not resulting in the underlying cause given in Part I.    C. Mayer, J.G.   Approximate interval bases on conspiculations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate interval bases on conditions and contributing in death.   Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate interval bases on conditions are consequence of its conditions.   Post in conditions, and consequence of its conditions, and consequence of its conditions, and consequence of its conditions.   Post in conditions, and consequence of its conditions, and consequence of its conditions, and consequence of its conditions.   Post in conditions, and	ortan Injur					new case.	Le, DL	
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Sequentially list conditions, larry, leading to immediate property of the season of th		resulting in deeth) a	Due to (or as a conseq	uence of):	^			
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Due to (or as a consequence of):    Cause (Diseases or Injury that Initiated events resulting in death) Last   C. Due to (or as a consequence of):	and I-tran	Sequentially list conditions,	Due to (or as a consequence	uence of):				
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Per III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   24b. Were autopsy available prior to completion of conditions of death   1   Yes   2   No   1   Yes   2	nding as a sea	d						
24a. Wes an eutopsy performed?  24b. Were autopsy performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Menner of Death  28d. Describe how injury occurred work?  28d. Location (Street and Number or Flural Route Num City or Town, Stete)  28d. Location (Street and Number or Flural Route Num City or Town, Stete)  28e. Place of Injury - At home, farm, atreet, factory, office  29e. Certifier (Check only one)  29e. Certifier (Check only one)  29e. Certifier on the desired occurred at the time, date and place, and due to the cause(s) and menner as stated.  29b. Signeture and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29b. Signeture and difference of Death (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)	d for	Port II. Other elemificant conditions contribut	ting to doubt but not equiling in the su	dadina asua aiua in	Deat 1 225 Die	I tabana una acatult	under the three manager of class	
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25. Was case referred to medical examiner?  1   Yes 2   No  27. Menner of Death   28a. Dete of Injury   28b. Time of thijury   28c. Injury at   28d. Describe how injury occurred   28d. Describe how injury occur	page Com				10	Yes 201No	1 Yes 2 No	
27. Menner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury At home, farm, atreet, factory, office 29e. Certifier 29e. Certifier 29e. Certifier 29e. Certifier 29e. Signeture and title of certifier 29b. Signeture and title of certifier 29b. Signeture and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Data filled (Month, Day, Year) 32. Registrate Signeture 33. Data filled (Month, Day, Year) 34. Data filled (Month, Day, Year) 35. Registrate Signeture 36. Other (Specify) 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Num City or Town, Stete) 28c. Location (Street and Number or Rural Route Num City or Town, Stete) 29c. Certifier 29c. Certifier 29c. Certifier 29c. License number 29d. Data signed (Month, Day, Year) 29d. Data signed (Month, Day, Year) 29d. Data signed (Month, Day, Year) 29d. Data signed (Month, Day, Year) 29d. Data signed (Month, Day, Year) 29d. Data filled (Month, Day, Year) 29d. Data filled (Month, Day, Year) 29d. Data signed (Month, Day, Year) 29d. Data filled (Month, Day, Year)	ctor.			26.	Place of Death (Check only	one)		
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29e. Certifier (Check only one)  29e. Certifier (Check only one)  29b. Signeture and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Begistraria Signature	ther the			28c. Injury at Work?	28d. Describe	how injury occurred		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wadhu S. Sachdeu M.D. – 322 E. Cecil Ave., Elkton, MD 21921	uneral cal cal Cal Cal Cal		i: To the best of my knowledge, death On the basis of examination and/or inv	occurred at the time, de	ate and place, and due to the	cause(s) and menne	or as stated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wadhu S. Sachdeu M.D. – 322 E. Cecil Ave., Elkton, MD 21921	The Med	one) a	nd manner steted.					
Macho S. Sachder M.D 322 E. Cecil Ave., Elkton, MD 21921	S C C	So. Signeture and title of certifier	den.	DOD 1	26183	4.3.00	Orin, Day, Year)	
31 Date filed (Month Day Year) 32 Begistrade Signature	10	0. Name and address of person who comple	ted cause of death (Item 23a) (Type, I	Print)				
31 Date filed (Month Day Year) 32 Benistrar's Signature	U	Madhu S. 30	wholey M.D.	- 322 E. Ce	ecil Ave., Ell	kton, MD	21921	
Registrar  APR 0 4 2000  Server G. Sporks	State	1. Dete filed (Month, Dey, Year)	32. Registrar'a Signature	£				

DHMH 16 Rav 6/95

ORIGINAL



#### Please Type or Print in Biack Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Joseph A. Vendemia, Sr. March 30, 2000 12:50 A.M. 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 379 Berkshire Drive Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) Days Yrs. 579-01-0357 Mar. 16,1915 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 XXVo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 379 Berkshire Drive 21140 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Detes: 14. Raca - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes ¾ XNo Specify: Specify: White 3√XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Brick Mason Construction 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Thomas V. Vendemia Anna Marssula 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas N. Vendemia/ Son 379 Berkshire Drive Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Ramoval from Stata Lakemont Meml. Gardens 4-3-00 Davidsonville, MD 4 ☐ Donation 5 ☐ Othar (Specify) George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) ate Quees Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hypene. Importants If flem 27 is marked other than "matural", or file

Hypiene.

altimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

or items 23s or 28s-f show striner must be notified at

Director

Funeral

þ

Completed

Be

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nding physician and use as the burial-transit signed by the attending d be detached for use as To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

that initiated events resulting in death) Last	Due to (d	or as e consequence of	):		
Pert II. Other significant conditions con	ntributing to death but not rec	sulting in the underlying	cause given in Pert I.	23b. Did tobacco uss	contribute to the cause of death?
				24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			26 Place of De	eath (Check only one)	7 100 2010
evaminer? t	lospital:	☐ ER/Outpatient 3☐ [	Home 5  Residence 6 □	Other (Specify)	
27. Manner of Death 15 Neturel 5 Pending 2 Accident Investigation	26a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury oc	curred
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, fectorify)	ory, office	28f. Location (Street and Nu City or Town, State)	imber or Rurel Route Number,
29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knoner: On the basis of axamino and manner steted.	owledge, death occurre etion end/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause(s) and curred at the time, date end plea	menner as stated. ce, and due to the cause(s)
29b. Signature and title of capture		2	9c. License number	29d. Date sig	gned (Month, Day, Year)
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Registrar DHMH 16 Rev 6/95

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31. Date filed (Month, Day, Year)

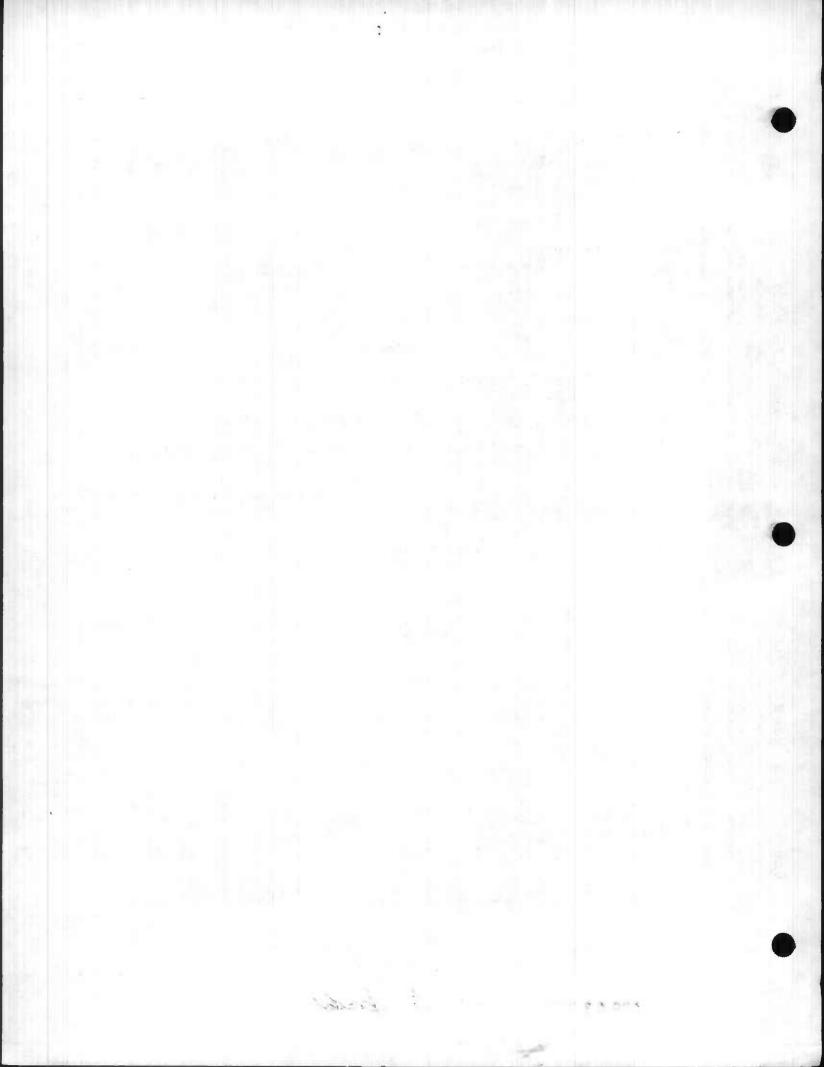
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geon who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signatura

and

Dannes ezer



State of Maryland / Department of Health and Mental Hygiene 00 1993

			Ce	rtificate of D	eath		Reg. No.	11220		
Physician	1. Decedent's Name (First, Middle, L.	,				2. Date of D Month		3. Time of Death		
/Medical		ASPERJ.	New		o. City, Town, or Le	3	230	D 8:126		
Examiner	4a Fscility Name (If not institution, gi 612 Andrew Hil	1 Road		1	Arnold	Callott of Dea		Arundel		
Funeral Director		Sex 7. Age (In your 180 M 2□ F 56	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Sept	ay, Year)	D. Birthplace (State or Foreig Country) South Africa		
dand dand	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits		
e Man	MD Anne Ar	undel Arm	nold					1 □ Yas 2 □N		
iter death with the Ma references to a 28a-1 s references to notifies Funeral Director	10e. Street and Number 612 Andrew Hill	Road		10f. Zip Code 21012			10g. Citizen of Wh South Af:			
by by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	? If Yas, specify Cuban, Mexican No 1 ☐ Yes 2 ☑ No Specify:			ecify Yes or N Rican, etc.)	o- 14. Race - Black, Specify:	American Indian, White, etc. White		
	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion uring most of work	ing	16b. Kind of Busi	ness/Industry		
Hygiene. Hygiene. Ther than "naturi ont, the Maries.  Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Owner	DO NOT use retired) r of Plast	ic Recyc	ling	Recyc:	ling		
be filed with tal Hygiene. d other than event, the	17. Father's Name (First, Middle, Las.				18. Mother's Name	Factor First, Middle	y , Maiden Sumame)			
nd Mental marked o	Casper Jan He	enrick Venter			Betty V	iljoen				
1 and 2 should be filed within Heath and Mental Hygiene. em 27 is marked other than ther traumetic event, the Ma	19a. Informant's Neme/Reletionship Linda Vanderspuy	Type, Print) / step-daugh	19b. Meili ter 61	ing Address (Street at 2 Andrew H	nd Number or Run Iill Road	al Route Numi	ber, City or Town, St 1d, MD 2	ate, Zip Code) 1012		
2 2 2 3	20a. Method of Disposition  1 Burial 2 XCremation 3 [ 4 Donation 3 Other (Special	Removal from State	cemetery, cre	osition (Name of matory or other place, ematory		iar 25	20c. Location - C			
Department of Important: If any Injury of 2008.	21. Signature of Fungful Service-Cice	2	В		Sons, P.			Funeral Hom		
-	23a. Parl T Enter the disease, or con short or heart failure. List only	optications thet caused the de	ath. Do not en	95 GOV R1 ter the mode of dying.	such as cardiac	or respiratory	verna Par arrest,	k, MD 21146 Approximeta Interval Between		
Physician								Onset and Death		
/Medical Examiner	Immediete Cause (Final disaasa or condition resulting in daath)	0	ARD	IAC P	mes?			i I		
		Due to	(or as a conse	quence of):	to.	. 15		1		
amir amir	Sequentially list conditions.	b. Due to	(or as a conse	quence of):	y temi	a L	abete			
physician and sthe burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events									
iding physician and use as the bunal-transit	resulting in death) Last  Due to (or ss a consequence of):  d.									
d by the attending etached for uses	Part it. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  23b. Dtd tobacco use-contribute to the cause									
igned by the a l be detached if by Physic				10	Hes 2 No 3	Probably 4 Unknown				
should should							s en eutopsy ormed?	24b. Were autopsy finding available prior to completion of cause of death?		
s certificate has director, page 2						10	Yes 2 No	1 Yes 2 No		
ribis certifica	25. Was case referred to medical examinar?				26. Place of Deat	h (Check only	oger			
his ce il dire To F	1 ☐ Yas 2 ☐ No	Hospital: 1 ☐ inpatient 2	☐ ER/Outpatie	nt 3 DOA Other	<sup>™</sup> 4□ Nursing Ho	me 5 Res	idence 6 □Other	(Specify)		
ter death.  Tector: After this of the funeral direction: To	27. Manner of Seeth  1		28b. Time o tnjury	Work?	at ? es 2 No	28d. Describe	how injury occurred			
the or Attanding in a later death.  al Director: After to led in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Ptece of tnjury - At building, etc. (Spe	home, ferm, str cify)	reet, fectory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,		
within 2 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one)  1 Certifying P	yacian: To the best of my ki pentir. On the Blass of exami and manner stated.	nowledge, deat netion and/or in	h occurred et the time vestigation, in my opi	o, date end place, nion, death occurr	and due to the red et the time	cause(s) and menr , date end place, an	ner as stated. d due to the cause(s)		
To the company	29b. Signatura and title of certifier	BW		29c. License	053193		29d. Date signed (			
	30. Neme end address of person who	completed pause of death (It	em 23a) (Type,	Print)	am		Maryland Prima	ry Care Physicians		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig		7,00			Amold,	MD 21012		
Registrar	MAR 2 7 20	00 prevena	Ø.	Soorka	/					

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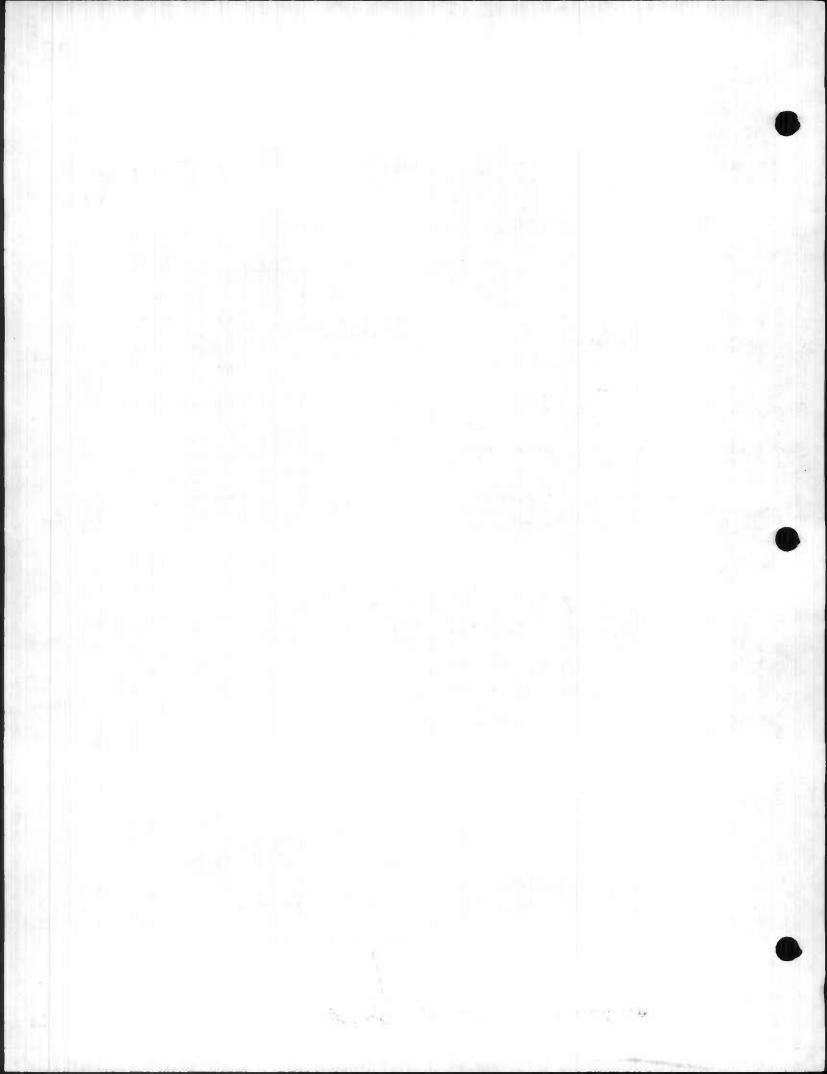
State of Maryland / Department of Health and Mental Hygiene 00 11994

							C	Certificat	e of	Death			Reg. No.				
	347-1	_	1. Decedent's Nam	ne (First, Middle, La	st)							2. Dete of De	eth				e of Death
	Physicia		Presi	ton 1. V	e(tmon	)						Month	Dey	-	Yeer	4:	30 min
à.	/Medica Examine	_			re street and number					4b. City, To	wn, or L	ocation of Deat	h 4c.		of Deeth		9), -
A	Examine	1			hesapeal					Arno	old		A	nne	Arı	ınde	1
	Funeval		5. Social Security N			ge (In yrs. las	t birtho	day) If Under		If Under		8. Dete of Bir	th		9. Birtho	lace /Sta	ate or Foreign
	Funeral Director		045-14-8 Usuel Residence o	728	I M 2□ F	87	Yn	Months	Deys	Hours	Min.	July 1	iy, Year)	912	Coun	higa	
	Mand Mand		10e. State	10b. County		10c. City, 7	Town o	or Location							1	0d. Insid	e City Limits
	the Maryland	Director	MD	Anne Ar	rundel	Sev	ern	a Park									Yes 2⊠No
	23a or	Tal Di	10e. Street and Nu 212 Old	County F	1				1146				US	SA	Vhat Coun		
020	0 0 5	Dy Fur	<ul><li>11. Maritel Stetus</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>	ried 2☑ Married 4 ☐ Divorced	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	? {No		13. Was Deced If Yes, spec	cify Cub	an, Mexice	n, Puerto	pecify Yes or No Ricen, etc.)		Blac	e - Americ k, White, White	etc.	1,
5-0	filed within 72 hours Hygiene. ither than "natural", int, ma Medical Exa	Completed	(Spec	15. Decedent's E	ducation		16a. D	ecedent's Usua Give kind of wo	al Occu	pation	t of worl	kina	16b. Kl	nd of Bu	siness/Ind	dustry	
2	e e	- Die	Elementary/Seco	T	College (1-4or	5+)	li	fe. DO NOT us	se retire	d)	. 01 11011						
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Maryland 21215-0020	d be sental	0 00		(First, Middle, Last, A. Veltma								e (First, Middle Platnga	, Maiden	Sumam	Θ)		
ary	2 shot and M le mer		19a. informant's N	ame/Relationship (	Type, Print)		19b. N	Mailing Address	(Stree	t and Numb	er or Ru	ral Route Numb	er, City o	r Town,	State, Zip	Code)	
	nd 2		Barbara	Veltman/	Wife		212	old Co	ount	y Roa	d s	Severna	Park	, M	D 211	46	
Baltimore,	Pages 1 a nent of Hea int: If Nam ary or othe	1	20a. Method of Dis 1 ☐ Buriel 2	position  Cremation 3	Removal from State	20b. Pled	a of D etery,	isposition (Ner crematory or o	ne of ther ple	(0)		lar 22	20c. Lo	cation -	City or To	wn, State	В
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Ba	Dept Impo		KA	2/2	Sun		_	Barrano 495 Gov				A. Sev	verna	Par Par	rk Fu	mera D 21	al Home
A.	Physician /Medical Examiner		show or hea	(Final	plicetions that cause one cause on each		lec	myt									Between and Deeth
Box 68760,	ing physicia e as the bur	Medic	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d														
m	death e atter	20	Part II. Other eignit	ficant conditions of	ontributing to death i	but not seculti	na in th	ne underwing c	ouee di	ven in Part		23h Did	tobacco	1180 000	atribute to	the cau	uee of death?
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ords	been should	Completed by	Ky	pulter	ion	1						24a. Was	an autopormed?	osy	av	allable pr	osy findings rior to of ceuse
<u> </u>	vicion: The lay certificata has rector, page 2	5	0.0									10	Yes 2	No	10	Yes	2 No
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ouo	lending Physician: eath. for: After this certific the funeral director,	TION I	27. Menner of Deet  1 Dentural  2 Accident	th 5 Pending Investigation	28a. Date of Inj (Month, Di	jury 28	3b. Tim Inju	ne of 2	28c. Inju Wo	- 1-		28d. Describe					
Divisi	or Attending P aftar death. Director: After t d in by the funera	Ceruncauon	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place of in	njury - At home etc. (Specify)	e, farm	, street, fectory	, office	8		28f. Location ( City or To	Street an wn, State	d Numb	er or Rura	I Route I	Vum <i>ber</i> ,
	Hospi 4 hou Funer taly fil		29a, Certifier (Check only one)		yelcian: To the best niner: On the basis of and manner s	of examinetion											se(s)
	To the H within 24 To the Fa completa		29b. Signature	title of certifier			-	290	. Licen	se number			29d. Dat	te signed	d (Month,	Day, Yea	ar)
	F 3 F 8		1/2	Welga	yMO	_		7	)-	405	21		Me	ard	421	,20	000
		:	30. Name and addr	ress of person who	completed cause of	death (Item 2:	3a) (Ty	oftin	35°	o Wi	1Ke	1229 AV	inue	_ 5	wite	30	2
	State Registra	,	31. Dete filed (Mon	AR 2 4 200	SZ. Mogist	trer's Signetur	6	do	and	4							

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MARTHA E. WOOD March 2.00 PM 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore CITY)BALTIMORE Hospita H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Director 216-18-5234 Usual Residence of Deceden TULY 25 1923 MARYLAND 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☑ Yes 2 ☐ No r must be notified MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Items 23s or STREET APT. 410 GLENWOOD 21401 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. r than "natural", or iter the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Yes. Give Specify BLACK by 3 Widowed ADDivorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Important: if flem 27 is marked other any Injury or other traumatic event. If poice. HUMANITARIAN SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mentel CLINTON WALLACE LaVERNA TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2853 HOMESTEAD DR. PETERSBURG, VA. 2380
Date 20c. Location · City or Town, State LAURA BLUME (DAUGHTER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANNAPOLIS NECK CEME. 3/27/00 ANNAPOLIS, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. tese arres WEST ST. ANNAPOLIS, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner coliti nemic physicien end s the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Myocardial infarcti Physician/Medical Due to (or as a consequence of): P.0. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown ascular signed b Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 : 2.21 No 1 Yes 1 Yes 20 No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Prin') Bul West Belvedere Avenue Baltimore MD 21215 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 8 2000 Registrar



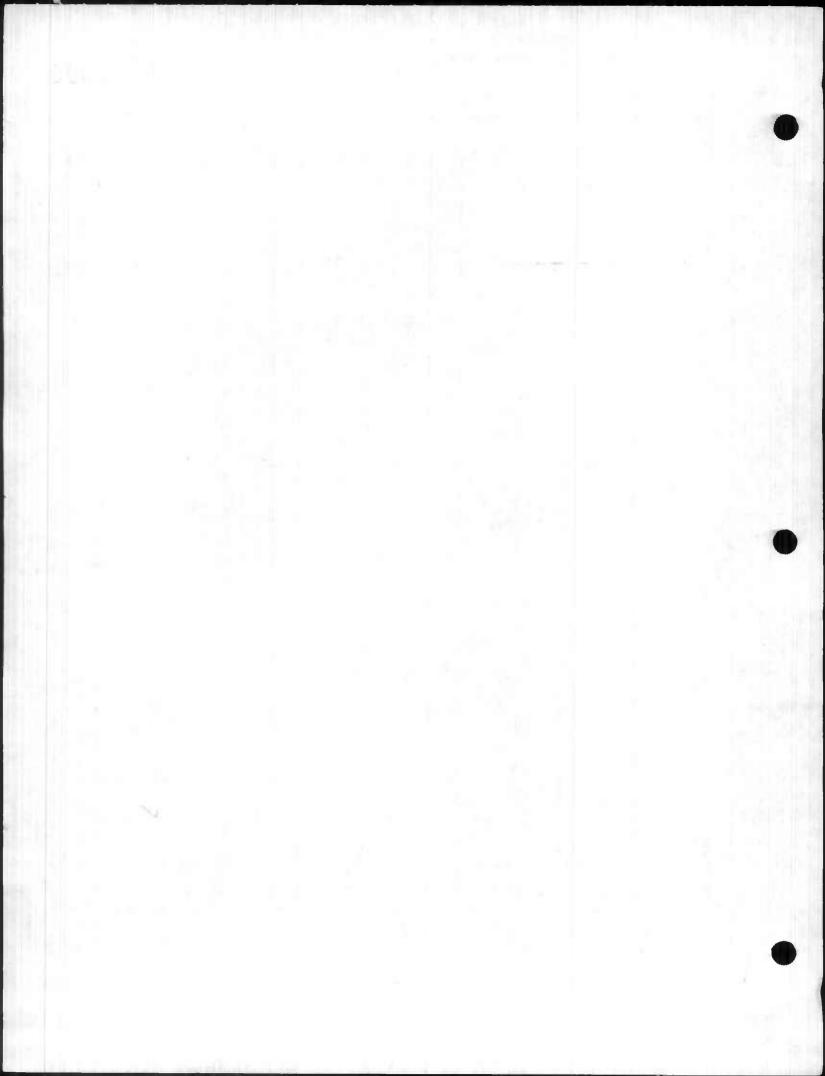
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #26 AMENDED ITEM #10e,10f PER FH G782 4/13/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2000 1:15 p.m /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore 8. Date of Birth (Month, Dey, Year) 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10 M XX 74 Director 228-28-9865 09 06 25 S.C Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at 1 Yes 2 No Directo or 25a-f MD Baltimore NA 10g. Citizen of What Country? 1701 EUTAW PLACE 10f. Zip Code 21217 Items 23s U.S.A. 21206 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 6 1 ☐ Yes 2X No Specify: by 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th grade 17. Father's Nama (First, Middle, Last) Nurse Assistant Levindale N/H 18. Mother's Name (First, Middle, Maiden Sumeme) or and Mental h Pages 1 and 2 should be Willie Spencer Sr. Alice Watson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) If item 27 i 9637 Muirkirk Road, Laurel Md 20707 Ronnie Allen-Son Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) b Metro Crematory Inc. 4/8/00 Baltimore, Md 22. Name and Address of Facility 21. Signature/of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician /Medical Immediate Cause (Final Colon disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Bud Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? director, page 2 should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown á of Vital Records, Be Completed by 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case raferred to medical DAUGHTER'S 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dothar (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) illed in by 4 Homicida within 24 hours a To the Funeral D To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 040854 5,2000 Agril MA 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Bultimer, MD 21202 Rusebos nne 31. Date filed (Month A PR 123 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

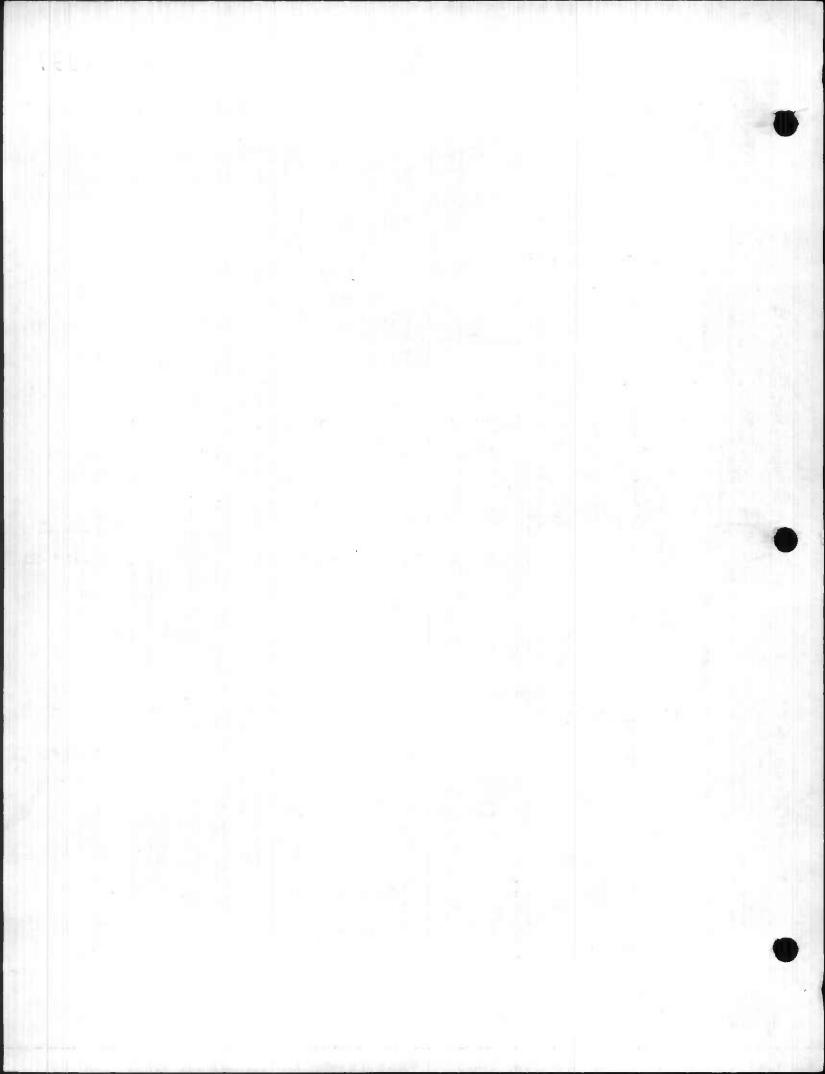
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State of Maryland / Department of Health and Mental Hygiene

AMEND ITE	EM: #31 PER F.H. G78	2 4-13-00 WR		ficate of			Reg. No.	0 11	997	
Physician /Medical	1. Decedent's Name (First, Middle, Last EVANGLEE ALLEN					2. Date of De Month	10 S	Year 10.	me of Death	
Examiner	4a Facility Name (If not institution, giva				4b. City, Town, or		,			
Funeral Director	5. Social Security Number 6. Se	SING HOME x 7. Age (In yrs 95		f Under 1 Year fonths Days	PIKESV   If Under 24 Hrs   Hours   Min	8. Dale of Bir	th sy, Year)	TIMORE  9. Birthplaca (S Country)  FORTLA	tate or Foreign	
8 .	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Locat	ion					ide City Limits	
eath with the Maryla ns 23e or 28e-f sho must be notified at eral Director	MD N	J/A	BA	LTIMOR	RE			₩ <u>`</u>	Yes 2 No	
or 28s-1 s be notified	10e. Street and Number		T	10f. Zip Code		T	10g. Citizen of \	What Country?		
23a and 3		ENUE		21215	5		U.S.	Α.		
Date Date of the Co.	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:		37	lispanic Origin? (5 an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	e - American India ck, White, etc. BLAC		
Maryland 21215-0020 d. 2 should be filed within 72 hours at the and Merital Hygiene. The marked other than "natural", or trainmetic event, the Medical Exams To Be Completed by F	15. Decedent's Edu (Specify only highast grad Elementery/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give kin	NOT use retired	during most of wo	orking		usiness/Industry		
D Hard	10th 17. Father's Neme (First, Middle, Last)		SELF	EMPLO		me (First, Middle		JNDRY		
yland Mental H Mental H rrked off rice ever						INGRA		,,,,		
View of the last o	19a. Informant's Neme/Relationship (7)	rpe, Print)	19b. Mailing /	Address (Street	and Number or R			State, Zip Code)		
	MARGARET F. CLO	OUD, DAUGHT	ER 4113	BOARN	IAN AVE	, BALTO	O. MD 2	21215		
Pages 1 Pages	20a. Method of Disposition  1 Burlal 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from Stata	Place of Disposition cometery, cremate RTLAWN	on (Name of ory or other place	ce)	Date	20c. Location -	City or Town, Sta		
Balt permit Depart Import any in	21. Signature of Funeral-Service Licens	66	HOW		ss of Facility UNERAL ERTY HG		E DATE	ro. MD	21207	
Physician /Medical Examiner	23a. Part1. Enter the disease, or composition in the control of th	Acute B	CCTGriCa for as a consequen	1 Pna				Interve	ximate al Between and Death	
Box 68760, sub certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
.O. Box the death cert y the attending sched for use.	Part II. Other algnificant conditions con	ntributing to doubt but not m	nulting in the code	adalara anusa ak	one in Part I	22h Did	tohanno una no	ntribute to the ca	use of death?	
is, P.O. Box es that the death certigned by the attending be detached for use a by Physician/M	Hx af Stroke	ithousing to death but not re-	Scharg III are unce	mying cause giv	ren in Fait i.		Yea 2□ No	3 Probably		
requir	•						an autopsy ormed?	24b. Were auto available a completio of death?		
The I						10	Yes 2 No	1 Tes	2 1 No	
of Vital Rec Physician: The law this certificate has trail director, page 2 s	25. Wes case referred to medical examiner?				26. Place of De	eth (Check only	one)			
Physic this of ral dire	1□ Yes 2⊡ No	1	1	3 DOA Oth	4 but Nursing i	Home 5 Resi				
Ing P Ing P	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe	how injury occur	red		
Division of Vital  Lo the Hospital or Attending Physician: T within 24 hours after death.  To the Funeral Director: After this certificat completely filled in by the funeral director, p	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci			Yes 2 No	28f. Location ( City or To	Street and Numb wn, State)	ber or Rural Route	Number,	
To the Hospital within 24 hours To the Funeral Completely filled	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my loner: On the basis of examine and manner stated.	owledge, death oc ation and/or invest	ocurred at the tin tigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and madate and place,	anner as stated. and due to the ca	use(s)	
To the comp	29b. Signature and little of certifier	1		29c. Licens	e number		29d. Dale signe	d (Month, Day, Ye	er)	
	> Nellough o	Lieu		1445	931		April	11,20	S	
MA	30. Name and address of person who co	e Heights	Huenu	el, Ba	elfima	ee, mi	2120	8		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Nnn	Granes	En	land.				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth April **Physician** 2000 5:15 AM Andreae Christian /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Forest Haven Nursing & Convalescent Home Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 14 M 2 □ F 8. Date of Birth Jan Year) 9. Birthpiece (Sta Jan 18, 1920 Mary Tand 9. Birthplece (State or Foreign **Funeral** Months Days Hours 80 218-09-5562 Yrs. Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 deeth with Herns 23a Funeral 4427 Mountain Rd. Pasadena USA 12. Was Decedent Ever In U.S. Armed Forces? 1 1 Yes 2 No 1943 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Stetus filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 □ Divorced White 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if Item 27 is merked other then eny Injury or other treumetra. Elementary/Secondary (0-12) College (1-4or 5+) Ship Fitter Ship Yard 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Theresa Andreae Elizabeth 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Wilbanks (Daughter) 604 Drain Dr. Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 1 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4/13/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, energiase on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 1 monter disease or condition resulting in death) **Examiner** Due to (or as e consequenca of) Examiner The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequenca of): ettending p P.O. I Part ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tronknown profic Neart signed t Records, þ page 2 should b 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Was an autopsy 1 ☐ Yes 2 ☐ No Sate 1 Yes 2 No of Vital To the Hospital or Attending Physicien: within 24 hours after death.

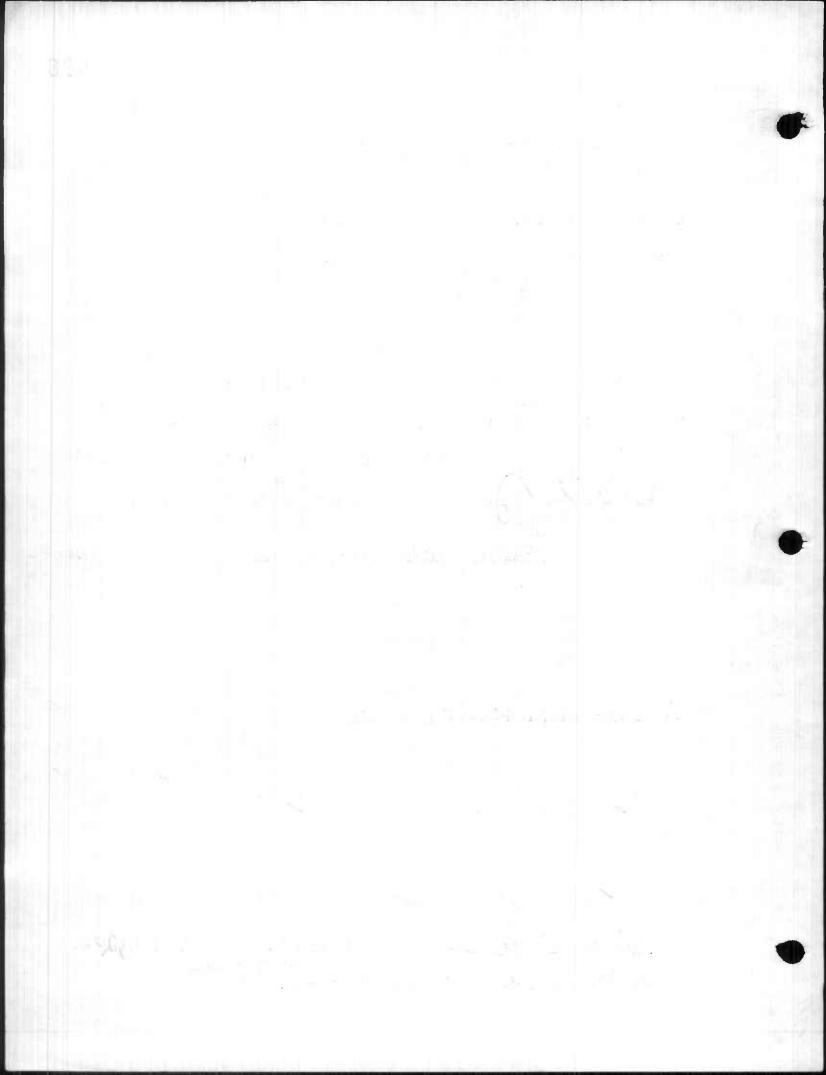
To the Funeral Director: After this cartifica complataly filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Medical Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ HomicIde 12 Certifying Phyalclan: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number H45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEBCKAH I PIBLE
7220 Paul Haghus Ausnus Baltmarc MJ) 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State APR 13 Denewar

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**DHMH 16 Rev 6/95** 

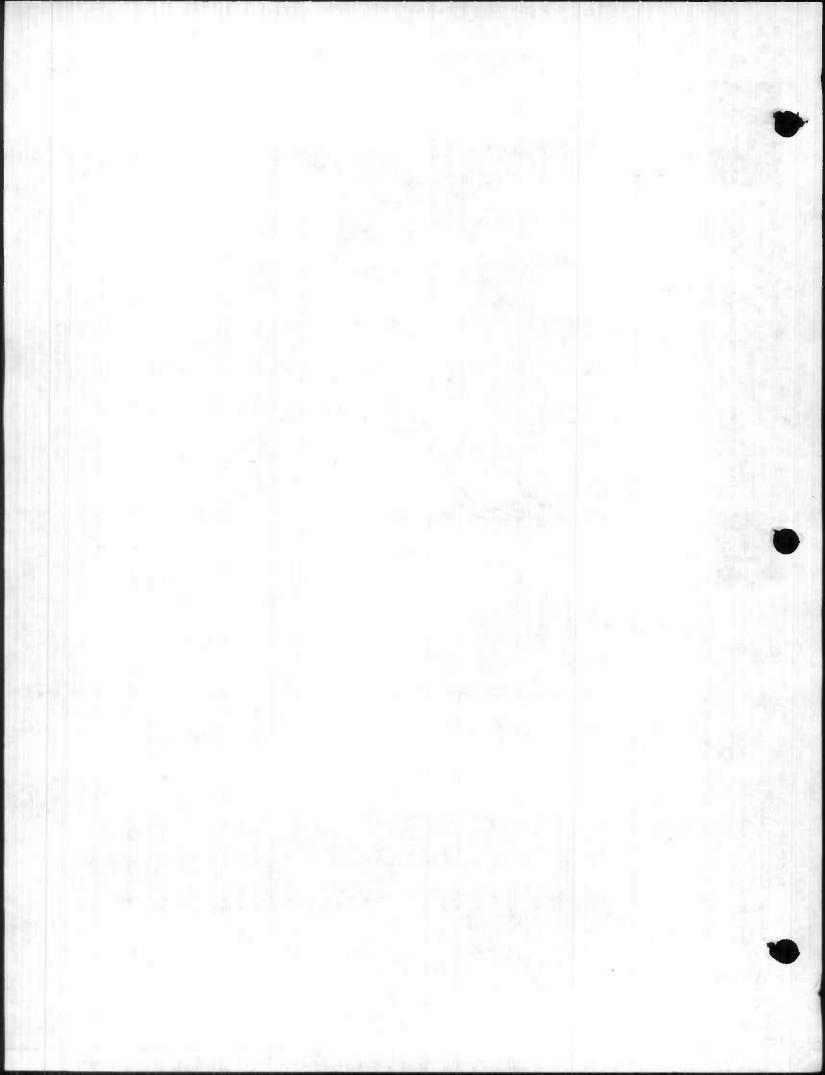
Registrar

2000



State of Maryland / Department of Health and Mental Hygiene 00

<b>Physician</b>		Decedent's Name (First, Middle, L.	ast)	700	30/1	ificate of		2. Date of De Month	Day	3. Tima of Death
/Medical	44	Facility Name (If not institution, gi		110			4b. City, Town, or	April)		1000 5 42 PM
Examiner	461	1/1/14	ve street and numbe	")			Palton	WW.	Roll	times CH
Funeral	5. S			Age (In yrs. I	ast birthday)	If Under 1 Yea Months Days			rth av Year)	Birthplace (State or Forg Country)
irector		12-44-2030	10 M 20 F	52	Yrs.	months Day.	TIOUTS IN	05//	9747	Md
B 11	-	ual Residence of Decedent  1. State 10b. County		10c. City	, Town or Loca	ation			*	10d. Inside City Lim
the story		Md N/A		Bal	timore					1/2 Yes 20
be notified	100	66 E. 27th Stree	ot			10f. Zip Code 2121	0		10g. Citizan of W	Vhat Country?
iner must	1	Marital Status	12. Was Deceder	at Ever in 11	S 13 W			Specify Vas or N	U S	e - American Indian,
by by		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force  1  Yas 2 /  If Yes, Give  Year or Dates	No No		Yes, specify Cu ☐ Yes 2 No	Hispanic Origin? (: ban, Maxican, Pua Specify:	rto Rican, etc.)	Black Specify:	k, Whita, etc.
to the Medical of the		15. Decedent's E (Specify only highest gr	Education rade completed)		16a. Decede	nt's Usual Occi	upation e during most of wo	orking	16b. Kind of Bu	siness/Industry
mod and	E	Elementary/Secondary (0-12)	College (1-4o	r 5+)	_	o <i>not</i> use retir nstress	ed)		Loudon	Fog Company
Sent, B	17.	10th grade Father's Name (First, Middle, Las	N/A		Jeun	113 01 033	18. Mother's Na	ma (First, Middle	, Maiden Sumam	θ)
ikad off		Daniel Boone					Gloria	Cunnin	gham	
a man		a. Informant's Name/Relationship		-			et and Number or F	lural Route Numi	per, City or Town,	
12.7 i		Phoebe Boone - [	Daughter			W. Mosh			imore, Mo	
nt: If lies	20a	Method of Disposition     WABurial 2 Cramation 3 [     4 Donation 5 Other (Speci		Kin	lace of Disposi ematery, crema g Memor	ition (Name of atory or other pi rial Pai	ace) ^K	4-15-00		Stown, Md
y inju	21.	Signature of Funeral Service Lice	nisee /	1	22.	Nama and Add	rass of Facility	1		
SEER		1/ Tala	Mare	h		4300 N	7/H West Wabash Ay	enue	Baltimore	e, Md 21215
	23	a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ears	ed the death line.	. Do not enter				arrest,	Approximate Interval Between
ysician ledical	Imi	mediate Cause /Final			-1	le .				Onset and Death
aminer	dis	mediate Cause (Final lease or condition sulting in death)	a. Fat		arrhy	and the same of th				30 minute
ةِ الله				Due to (or	ras a consety	ence ot):				
iclan and burial-transit	Se	quentially list conditions,	b. ———	Due to (or	as a consequ	ence of):			_	
C E X	15 0									
8 5 T	cau	uny, leading to immediate use. Enter Underlying use (Disease or Injury								
ysicle be bui	cat Ca tha res	quentially list conditions, iny, leading to immediate use. Enter Underlying use (Disease or Injury it initiated events culting in death) Last	C	Due to (or	as a conseque	enca of):			eller in	
physicle as the bu	Car tha res	iny, leading to immediate use. Enter Underlying use (Disease or Injury it initiated events utiliting in death) Last	c	Due to (or	as a conseque	enca of):				
physicle as the bu	Car tha res	suiting in death) Last					thus in Part I	23h Die	I tohacco use con	atribute to the cause of de
physicle as the bu	Car tha res	iny, leading to immediate use. Enter Underlying use (Disease or Injury It initiated events uulting in death) Last	contributing to death	but not rasu	ulting in the unc		jiven in Part I.		l tobacco uee con	
physicle as the bu	Car tha res	suiting in death) Last	contributing to death		ulting in the unc		given in Part I.			
physicle as the bu	Car tha res	suiting in death) Last	contributing to death	but not rasu	ulting in the unc		given in Part I.	1 [ 24a. Wa		3 Probably 4 ☐ Unkr
physicle as the bu	Car tha res	suiting in death) Last	contributing to death	but not rasu	ulting in the unc		given in Part I.	1 [ 24a. Wa	Yee 2 No	3 Probably 4 ☐ Unkr
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certificate has been signed by the attending physicia rector, paga 2 should be detached for use as the but be been been been been been been been	Car tha res	till. Other eignificant conditions  CORONARY  Was case referred to medical examine?	terry d	but not resu	ilting in tha unc	derlying cause (	26. Place of Do	24a. Wa per 1 = eath (Check only	yee 2 No s an autopsy formed?  Yes 2 No one)	24b. Were autopsy findin available prior to completion of cause of death?  1 Yes 2 No
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iter this certificate has been signed by the attending physicial uneral director, page 2 should be detached for use as the but on: To Be Completed by Physician/Medical	Cartha res	Was case referred to medical examiner?  1   Yes   2   No   Manner of Death 1   Natural   5   Panding investigated	Hospital: 1 Inpa	but not rasu	elting in tha unc	derlying cause of a state of the state of th	26. Place of Do other: 4 ☐ Nursing	24a. Wa per 1 = eath (Check only Home 5 = Res	yee 2 No s an autopsy formed?  Yes 2 No one)	24b. Were autopsy findin available prior to completion of cause of death?  1 Yes 2 No
iter this certificate has been signed by the attending physicial uneral director, page 2 should be detached for use as the but on: To Be Completed by Physician/Medical	Cartha res	Was case referred to medical examiner?  I yes 20 No  Manner of Death  Natural 5 Panding	Hospital: 1 Inpa  28a. Date of Ir (Month, I) 28a. Placa of Ir 28a. Placa of Ir	but not rasu  Sease  tient 2 tient 2 tient	ER/Outpatient 28b. Time of Injury	derlying cause of a state of the state of th	26. Place of Dother: 4 \( \text{Nursing} \) ury at ork? \( \text{Yes} \) 2 \( \text{No} \)	24a. Wa per 1 = 24b. Check only Home 5 = Res 28d. Describe	Yes 2 No  No 2 No  S an autopsy lormed?  Yes 2 No  one)  Sidence 6 Other occurry	24b. Were autopsy findin available prior to completion of cause of death?  1 Yes 2 No
iter this certificate has been signed by the attending physicial uneral director, page 2 should be detached for use as the but on: To Be Completed by Physician/Medical	Caithan res	Was case referred to medical examiner?    Was case referred to medical examiner?    Yes   2 No	Hospital: 1 Inpa  28a. Date of Ir (Month, I)  28a. Placa of I building,	but not rasu  Sease  Sease  tient 2 to sijury  ay Year)  injury - At horacic. (Specify,  st of my know of axaminati	ER/Outpatient 28b. Time of Injury	30 DOA C 28c. In W W 11 et, factory, office	26. Place of Do  Other: 4 \( \text{Nursing} \)  ury at ork? \( \text{Yes} \) Yes 2 \( \text{No} \)  e  time, date and place	24a. Wa per 1 = 24b. Check only Home 5 = Ret 28d. Describe 28f. Location City or Total 28f. and due to the	Yes 2 No  s an autopsy formed?  Yes 2 No  one)  sidence 6 Other how injury occurr  (Street and Numbown, State)	24b. Were autopsy findin available prior to completion of cause of death?  1 Yes 2 No  er (Specify)  red  er or Rural Route Number,
iter this certificate has been signed by the attending physicial uneral director, page 2 should be detached for use as the but on: To Be Completed by Physician/Medical	Calabana Pari	Was case referred to medical examiner?  I Natural 2 Accident 3 Suicida 4 Homicide	Hospital: 1 Inpa 28a. Date of Ir (Month, I be 28a. Placa of building, hysician: To the bes	but not rasu  Sease  Sease  tient 2 to sijury  ay Year)  injury - At horacic. (Specify,  st of my know of axaminati	ER/Outpatient 28b. Time of Injury	30 DOA C 28c. In W 11 et, factory, office cocurred at the stigation, in my	26. Place of Do  Other: 4 \( \text{Nursing} \)  ury at ork? \( \text{Yes} \) Yes 2 \( \text{No} \)  e  time, date and place	24a. Wa per 1 = 24b. Check only Home 5 = Ret 28d. Describe 28f. Location City or Total 28f. and due to the	S an autopsy formed?  Yes 2 No one)  Sidence 6 Other one one one one one one one of the other or one one one one of the other of the other one one of the other	24b. Were autopsy finding available prior to completion of cause of death?  1 Yes 2 No  er (Specify)  red  er or Rural Route Number,  unner as stated.
The fundable detection and the first certificate has been signed by the attending physicial between billied in by the funeral director, page 2 should be detached for use as the builded in by the funeral director, page 2 should be detached for use as the builded Certification: To Be Completed by Physician/Medical	Calabana Pari	Was case referred to medical examiner?    Was case referred to medical examiner?   Yes 2 No   Manner of Death   1 Natural   2 Accident   3 Suicida   4 Homicide   1 Certifying Piccheck only one   1 Certifying Piccheck only   2 Medical Examiner.	Hospital: 1 Inpa 28a. Date of Ir (Month, I be 28a. Placa of building, hysician: To the bes	but not rasu  Sease  Sease  tient 2 to sijury  ay Year)  injury - At horacic. (Specify,  st of my know of axaminati	ER/Outpatient 28b. Time of Injury	304 DOA C 28c. In W M 11 et, factory, office cocurred at the stigation, in my 29c. Licar	26. Place of Dither: 4 Nursing ury at ork? Yes 2 No e	24a. Wa per 1 = 24b. Check only Home 5 = Ret 28d. Describe 28f. Location City or Total 28f. and due to the	S an autopsy formed?  Yes 2 No one)  Sidence 6 Other one one one one one one one of the other or one one one one of the other of the other one one of the other	completion of cause of death?  1  Yes 2 No  er (Specify)  red  er or Rural Route Number,  unner as stated.  and due to the cause(s)  d (Month, Day, Year)
iter this certificate has been signed by the attending physicial uneral director, page 2 should be detached for use as the but on: To Be Completed by Physician/Medical	25. 27. 29b	Was case referred to medical examine?    Was case referred to medical examine?   Ves   Hospital: 1 Inpa 28a. Date of Ir (Month, I be) 28a. Placa of I building, hysician: To the bes miner: On the basis and manner	but not rasu    Season   Seaso	ER/Outpatient 28b. Time of Injury me, farm, street)	derlying cause of the street o	26. Place of Do  Other: 4 Nursing ury at ork? Yes 2 No e  time, date and place opinion, death occurs na number	24a. Wa per 1 Check only Home 5 Res 28d. Describe 28f. Location City or 7 ce, and due to the turred at the time	S an autopsy formed?  I Yes 2 No one)  Sidence 6 Other one one one one one one one of other or one one one one one of other or one one of other or one one of other or one of	24b. Were autopsy findin available prior to completion of cause of death?  1 Yes 2 No  er (Specify)  red  er or Rural Route Number,  unner as stated. and due to the cause(s)	



State of Maryland / Department of Health and Mental Hygienes

Physician	1. Decedent's Name						Death	2. Date of Dea		Year	me of Death
/Medical	Arthur V	William 1	Barry					April 1	2, 2000	4:	00 A.M.
Examiner	4a Facility Name (#			ber)				Location of Death	4c. County of	of Death	
		okfield 1				If Under 1 Year	Pasadena   If Under 24 Hr			Arundel	
Funeral Director	5. Social Security No. 081-07-40.  Usual Residence of	31	Sex 7 1⊠ M 2□ F	92	last birthday) Yrs.	Months Days	Hours Mir		r, Year)	9. Birthplace (S Country) New Yor	tete or Foreign k
8 m	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation				10d. Ins	de City Limits
to to	Maryland	Anne Art	undel	Pas	adena					1□	Yes 2⊠No
or 28s-fa be notified Director	10e. Street and Nun	nber				10f. Zip Code			l 0g. Citizen of W	That Country?	
23a c	308 Brook	kfield Ro	a.			21122			United	States	
natural, or tems 23a or 28a-f show tideal Examinat must be notified at leted by Funeral Director	11. Merital Stetus  1 Never Marrie 3 Widowed	ed 2 Married 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Yeer or Det	es? !⊠ No		Was Decedent of If Yes, specify Cut 1☐ Yes 2점 No		Specify Yes or No- rto Rican, etc.)		- American tndi k, White, etc. White	an,
ygiene. Ner than "naturn It, ma Madical Completed	(Speci	15. Decedent's E lify only highest grandary (0-12)	ducation ade completed) College (1-	for 5+)	life. L	dent's Usuat Occu kind of work done DO NOT use retire	pation during most of wid)	orking	16b. Kind of Bus	nu.	
ant, the Men	11				Painte	er				ment Sto	re
marks avant, ma M	17. Father's Name (		)				18. Mother's Ne	me (First, Middle,	Maiden Sumame	9)	
To	John M.				T						
T'le m treum	19a. Informant's Na Virginia					_		Rural Route Numbe Pasadena,			
m 27 ther tr	20a. Method of Disp		Daughter	20b. I	Place of Dispo	sition (Name of		Date		City or Town, Sta	
Important: If item 27 any injury or other to once.	4 Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specif	<b>(y)</b>	919	dar Hi	netory or other pla 11 Cemet	ery	Apr. 14 2000	Brookly		
any ir	22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, M. 23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.										061
edical miner	tmmediate Cause (Final disease or condition resulting in death)  e. CONGESTIVE HEART FAILURE  Due to (or as a consequence of):										
s the burial-transit	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	nditions, imediate rlying injury	c	CDue to (or as a consequence of):							
D =	resulting in death) L	ast				delice oil.				1	
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ed for use	Part II. Other signification	cant conditions			1 T(			23b. Did t	obacco use con	tribute to the ca	use of death?
oned by the oe detached by Phys		icant conditions of	contributing to dea	th but not res	ulting in the ur	nderlying cause gi			obacco use con ′es 2□No		
2 should be detached pleted by Physical			contributing to dea	th but not res	ulting in the ur	nderlying cause gi		1 🗆 1		3 Probably  24b. Were auto available	4 Unknown
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